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# NEW JERSEY MEDICINE

January 1996

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

## SPECIAL ISSUE

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# Newswatch

## MSNJ LOBBYISTS LURE LEGISLATORS IN LAME DUCK . . .

During the busy “lame duck” session of the state Legislature, the Medical Society of New Jersey (MSNJ) was seeking to persuade state Senators and Assembly members to increase the tax on tobacco, preserve the “Access” program of subsidized health insurance, prevent the optometry profession from obtaining authorization to practice medicine, and prepare to adopt major controls on managed care.

Typically, a New Jersey legislature saves many of its major battles until the waning days of its existence, between state elections in November of odd-numbered years and the establishment of a new legislature the following January. The current situation mirrors the mind-boggling pattern.

At press time (which was unusually early this month due to the holidays), the outcome of the major health-related issues remained very much in doubt.

The bulk of attention in early and mid-December was focused on the financing of charity care, which includes reimbursement of inner-city hospitals and the recently created “Access” program.

MSNJ saw the state’s dilemma of developing a new funding stream as an opportunity to promote a higher tobacco tax. Research shows that an increase in the tobacco tax has the highly beneficial effect of discouraging teenagers and younger children from purchasing cigarettes and other addictive tobacco products.

Because approximately 90 percent of all smokers start smoking before the age of 21--and at an average age of 14--youth tobacco sales are crucial to the tobacco industry’s nefarious efforts to develop new markets for its products. Tobacco-related disease accounts for approximately 10,000 deaths in New Jersey annually.

Encouraged in part by MSNJ’s strong advocacy, Governor Christie Whitman came out swinging in favor of the higher tobacco levy. The state’s chief executive tied the tax to a new program to subsidize insurance premiums at a generous level for children in families with incomes up to 250 percent of the poverty index.

Governor Whitman’s position was considered courageous, in view of her essential reputation as a tax-cutter.

In a curious development, the state Chamber of Commerce twice conducted surveys in December to ascertain the views of Chamber members toward a tobacco tax and other charity care funding proposals. Results of the first survey were thrown out when Chamber officials learned that the state's powerful tobacco interests had attempted to skew the results. In the second, tamper-free survey, 88 percent of respondents supported the tobacco tax--a remarkable showing for the conservative Chamber membership.

MSNJ lobbyists met with initial success in stopping the optometry bill. Because optometrists had been generous with political contributions, the MSNJ effort had been seen as an uphill battle. The state academy of ophthalmology also was heavily invested in the fight, which, if won by the optometrists, would have created a precedent for other nonphysician groups to expand their own scopes of practice.

Using real cases, MSNJ also was demonstrating that certain insurers and HMOs appeared to be ignoring or frequently circumventing a new state law requiring the third-party payers to allow newborns and their mothers to stay in hospitals for at least 48 hours following a normal vaginal delivery, and 96 hours following a cesarean section.

MSNJ led the campaign to get the "48-hour" bill enacted earlier in 1995. The state law helped inspire similar efforts in the U.S. Congress.

Testimony also was provided by MSNJ to support legislation--termed the "Patient Protection Act" in the Assembly, and the "Health Care Quality Act" in the Senate--that would place more controls on managed care. Several consumer groups also supported the legislation, which is expected to become a major battle during 1996 due to fierce resistance from HMOs.

On the regulatory, or non-legislative, front, MSNJ scored a victory in helping to persuade the state Insurance Department to back off an earlier proposal to permit health insurers to deny coverage to HIV-positive individuals. MSNJ noted that the proposal was discriminatory and would encourage insurers to seek to deny coverage to patients with other disease-related conditions.

Finally, regulatory steps were being taken to shore up Health Commissioner Len Fishman's November 17 proposal to overhaul state regulations on HMOs. Commissioner Fishman and MSNJ spokespersons believe that the new regulations, if adopted in their proposed form, would be the strongest in the nation.

January 1996



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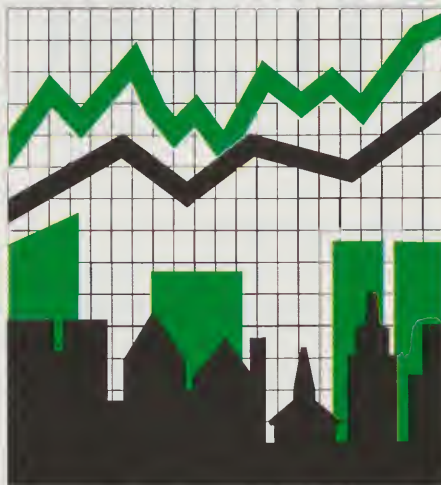
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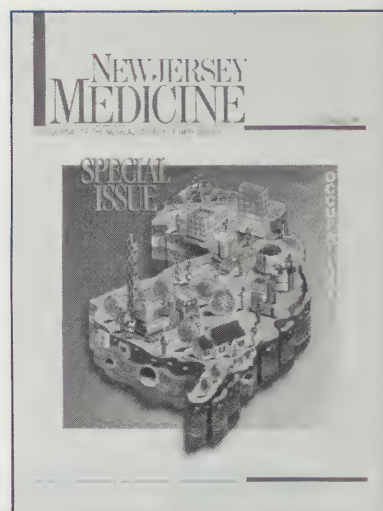
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# NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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# MSNJ NEWSLETTER

## THE FORTUNES OF CAPITATION

"Eventually, the infatuation with capitation will fade as payers learn that it is, at best, only part of the solution to rising health care costs," states *Medicine & Health Perspectives*. This publication suggests this is an emerging consensus among health care industry analysts.

The experts are said to believe that better cooperation and communication with and among providers will be seen ultimately

as essential to effective cost containment. Additionally, better information systems and patient education will be used to hold down costs, according to the newsletter's sources.

But, the HMO approach will continue to flourish until managed care companies and payers slowly come to the realization that capitation is only a limited strategy, the experts admonish.

## CLIA AND PHYSICIANS' OFFICES

In a 14-page report disseminated by the conservative Heritage Foundation, Sandra Mahkorn, MD, MPH, has slammed regulation of physician office laboratories under the Clinical Laboratory Improvement Amendments (CLIA) of 1988 and related legislation.

Dr. Mahkorn asserts that CLIA has caused a decline in the percentage of laboratory tests performed in physician offices from about 50 percent of all tests to about 7 percent. She criticizes the use of proficiency testing as a regulatory tool, noting that analytes that are accurate for one

type of machine often are inaccurate for other types, and that such specimens often are drawn from nonhuman sources and may have been frozen and thawed numerous times.

Declaring that the CLIA approach addresses what is essentially a nonproblem, a suspected huge number of errors in laboratory tests conducted in physicians' offices, Dr. Mahkorn says that patients pay the cost for the legislation in higher fees, long delays, return visits, and required travel from one office or facility to another.

## 1996

## MSNJ Board of Trustees Meeting Schedule

**January 21, 1996**

**February 18, 1996**

**March 17, 1996**

**April 14, 1996**



## HEALTHCARE NETWORKS OF AMERICA

An alert about Healthcare Networks of America and its corporate parent, Allied Group Network, has been circulated by the American Medical Association/State Medical Society Litigation Center.

The self-styled network may engage in high pressure sales tac-

tics, inappropriate fee demands, unauthorized charges to physicians' credit cards, refusals to abide by refund agreements, and a failure to provide patients as promised, suggests the Center.

## CRYPTOSPORIDIUM

As reported in these pages in August, the New Jersey State Department of Health is engaged in an information campaign regarding *Giardia* and *Cryptosporidium*, the parasites associated with drinking water in some com-

munities. Individuals with severely weakened immune systems are most at risk. Informational booklets are available for clinicians and patients. Contact Susan House at MSNJ, 609/896-1766.

## HEALTH DATA COMMITTEE

Health Commissioner Len Fishman reportedly has named Eileen M. Moynihan, MD, a rheumatologist and the treasurer of MSNJ, to an important new committee on data and managed care. Named the Health Data Committee (HeDaC), the group

was proposed by MSNJ representatives and other participants in the Commissioner's HMO Advisory Committee as a way to assure that state data collection requirements are reasonable. Dr. Moynihan is a member of the Camden County Medical Society.

## NEW JERSEY BLIND REGISTRY

Based on New Jersey statute 30:6-1, New Jersey physicians are mandated to report blind and visually impaired patients to the Blind Registry. The Registry is essential for the planning of services; management and evaluation of programs; and providing

medical data contributing to the prevention of blindness. If you have any questions or need the appropriate forms, please contact Mrs. Janice Snead, Registrar, Department of Human Services, Commission for the Blind and Visually Impaired, 201/648-6237.

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# PROFESSIONAL LIABILITY

## MALPRACTICE VERDICTS

**Knee infection.** After the onset of pain in the knee, a man in his 50s, previously diagnosed for psoriatic arthritis, underwent an arthrogram for the purpose of ruling out the possibility of a meniscal tear. Results were negative for pathology, but a few days later the patient experienced increasing irritation that led him to visit a hospital emergency department.

At the emergency department, the patient was seen by an orthopedic surgeon, who was covering the unit. A culture was taken, and the physician discharged the patient with instructions to revisit the orthopedic surgeon who had ordered the arthrogram. In addition, the emergency department physician prescribed a course of antibiotics.

The culture came back positive for the presence of infection, but the physician did not forward the results to the patient's original orthopedic surgeon. When the patient dutifully revisited his original orthopedist, that physician withdrew the antibiotics and conducted his own culture, which came back negative.

Three weeks later, a third culture was taken, again producing a negative finding. One week later another culture led to a positive result.

Degeneration of the knee continued. A knee replacement was recommended, but delayed due to symptoms associated with cancer of the lung.

The patient brought a malpractice action against both orthopedic surgeons, alleging that the physician in the emergency department had negligently failed to forward the positive result of the first culture and that the original physician had negligently relied on the negative result of

the second test when antibiotics could have masked the presence of an infection.

According to the plaintiff, the physicians' negligence necessitated a knee replacement. The patient's cancer had been in remission for four years when the case came to trial in New Jersey.

In defense, the emergency department physician maintained that the positive result of the first test was explained by the presence of a small amount of strep bacteria, indicating contamination of the sample. The other original physician asserted that he had treated the patient appropriately by relying on the results of his own test, discontinuing the antibiotics, and carefully monitoring the patient.

Both defendants claimed that the degeneration was caused by the arthritis. The jury found for the defendants.

**Postanesthesia care.** A cyst was excised from a 29-year-old maintenance man during surgery performed under general anesthesia. A preoperative pulse rate of 56, and a postoperative rate of 90 were recorded. In the postanesthesia care unit, a rate of 60 was recorded.

Eight minutes later, a physician attending another patient observed a nurse attempting to awaken the cyst patient. Glancing at the monitor, the physician saw a flat line signaling a zero pulse and immediately called a code. The anesthesiologist returned and, following several attempts, intubated the patient. The patient lapsed into a coma and died five months later, leaving a wife and two children.

A malpractice action was brought in New Jersey against the anesthesiologist, the nurse, and another assisting nurse. The

plaintiff claimed that the anesthesiologist was negligent in not remaining with the patient when the rate fell to 60, and in not intubating the patient more rapidly.

The plaintiff further claimed that the nurse was negligent in failing to provide proper monitoring and failing to call a code when the pulse fell to zero. The assisting nurse also was faulted for failing to call a code.

Damages were sought in the amount of \$712,000 for lost earnings, plus additional amounts for the children's loss of guidance and for the patient's five months loss of enjoyment of life while comatose.

An expert anesthesiologist testified for the plaintiff that an abnormally large amount of anesthesia had been used, necessitating especially careful monitoring, including the anesthesiologist's continued presence once the pulse rate began to decline. The expert also contended that the five minutes that, according to the record, were taken by the defendant anesthesiologist to intubate the patient, amounted to a definitely excessive period.

Agreeing that five minutes was too long for an experienced anesthesiologist to need to intubate a patient, the defendant anesthesiologist insisted that the actual duration was only one to two minutes. The defendant noted that the five-minute notation was made by a nurse, acting after the incident had occurred. It was further observed that the pulse rate had been zero for some time before the intubation was attempted, so that a successful intervention was unlikely.

Further, the defendant anesthesiologist observed that the patient's initial pulse rate had been

56, so that the reading of 90 apparently reflected a temporary agitated response to anesthesia. The gradual decline back to 60, continued the defendant, was not in itself a cause for substantial concern.

The lead nurse defendant claimed that she had provided proper monitoring and that the drop in pulse rate from 60 to zero had been so precipitous that she lacked time to call a code. The plaintiff's expert anesthesiologist suggested that this explanation was unlikely, especially in view of the earlier decline from 90 to 60.

An expert nurse testified for the plaintiff that the lead nurse defendant had been negligent, but offered no substantial criticism of the assisting nurse. Accordingly, at the close of the plaintiff's case, the charge against the assisting nurse was dismissed.

After retiring, the jury returned to inquire whether it could impose liability on anyone other than the remaining two defendants. The court explained that

only the physician and nurse listed on the verdict sheet could be assigned liability.

Thus instructed, the jury determined that the lead nurse was negligently liable, the physician was not negligently liable, and that damages included \$600,000 for lost income, \$33,500 for the children's loss of guidance, \$9,000 for loss of enjoyment of life, and \$7,500 for the widow's loss of consortium during the duration of the coma.

**Gastric complaints.** After experiencing constipation, diarrhea, and other gastric problems over a period of several months, a 48-year-old man visited a gastroenterologist. Suspecting that antibiotics could be causing the distress, the physician discontinued a prescription for antibiotics and proceeded to monitor the patient.

Two months later the physician conducted an upper GI series, with results that were consistent with duodenitis. Two later attempts at a barium enema failed, and the patient did not keep an

appointment for a third attempt.

Four months after the initial visit, the patient was diagnosed with diverticulitis. The large intestine was excised. A colostomy bag was required for two months, and the patient remained at risk for fecal accidents and under a restricted diet. He charged the physician with malpractice in a New Jersey court action.

The physician's failure to order a barium enema and sigmoidoscopy upon the initial visit was cited by the plaintiff as the cause of the damage to the intestine that necessitated the surgery. But, the defendant stressed that these actions, taken in the case of a patient with diverticulitis, could be fatal, so that conservatism was indicated.

The parties stipulated that a vote of at least 6-2 among the jurors, including alternates, would be acceptable as a decision. The 6-2 tally went for the defense.

## MALPRACTICE AND OTHER CASES

**ERISA pre-emption: 1 for, 1 against.** In two cases recently summarized by *Hospital Law Manual Bulletin*, the Tenth and Eleventh U.S. Circuit Courts of Appeal produced somewhat contrasting decisions interpreting the scope of federal pre-emption of health insurance regulation under the Employee Retirement Income Security Act (ERISA).

In a medical malpractice case, the Tenth Circuit held that ERISA does not preclude a claim that a health maintenance organization (HMO) was vicariously liable for the conduct of one of its plan physicians. The decision, up-

holding a district court ruling, rested on the court's conclusion that the claim did not turn on the details of the plan itself.

But, in a case involving an HMO's rescission of its earlier precertification decision, the Eleventh Circuit ruled against a hospital seeking payment for chemotherapy administered to a plan enrollee. In the patient's 20th admission to the hospital for lymphoblastic leukemia, the hospital obtained preliminary approval. But, later the HMO changed its mind, deciding that the treatment was experimental and, therefore, not covered.

The appeals court supported none of the hospital's theories seeking to force the HMO to abide by its initial decision. There was no reasonable reliance on the precertification, said the court, as evidenced by the HMO's ultimate decision. Nor, the judges continued, did the previous course of dealing establish a waiver of the experimental exclusion.

Finally, the court held that the issue of whether the treatment was medically necessary and thus reimbursable was a question of plan administration that is pre-empted under the federal legislation.

## HEALTH CARE FINANCING

**Assessing medical savings accounts.** The hottest new health reform initiative, medical savings accounts (MSAs), received an ambivalent review from the American Academy of Actuaries.

The Academy's analysis is that MSA participation, if buffered by legislation that would make MSAs tax exempt, would start slowly but generally appeal to young, single people and those people with

high incomes. But, the Academy determined that MSAs would have only limited appeal among people with low incomes, people who are risk-averse, and HMO enrollees. In a printed report, the



prestigious Washington, DC-based organization suggested that Congress should consider facilitating HMO arrangements as part of any MSA legislation.

More favorable mention of MSAs occurred in a *Business & Health* cover story. The magazine quoted Jersey City Mayor Bret Schundler as finding "happier and healthier employees, some immediate cost savings, and the prospect of significant premium reductions in the future" under an MSA deal for city employees being struck with Golden Rule Insurance Co., the Illinois-based firm most closely associated with MSA success in a corporate environment.

Under MSA plans, employers purchase catastrophic health insurance for employees. Taking most of the money saved by not purchasing more generous coverage, the employers then deposit funds in accounts that can be accessed only by individual employees and only for the purpose of purchasing health services. The funds accrue interest and adhere to the individual if the individual changes jobs.

MSAs therefore create an incentive for individuals to avoid unnecessary health care expenses. In addition, MSAs free employers from the expense of processing small claims.

Critics contend that MSAs would "skim" healthy people off the rolls of comprehensive insurance plans, which therefore could become prohibitively expensive for most less healthy individuals. The critics also believe that MSAs would aggravate the massive nationwide problem of uninsured individuals.

The latter claim is disputed especially strongly by MSA advocates, who argue that MSAs would hold particular appeal to

populations that are younger and less solidly entrenched in the job market—in short, the groups that form the backbone of the uninsured.

Much of the controversy swirling about MSAs centers on their relationship to HMO participation. Some physician champions of MSAs appear to believe that MSAs could revive the declining market for fee-for-service medicine.

But, many advocates within the business community contend that MSAs would allow HMOs to focus their attention on patients with more costly health care requirements, where HMOs can yield the greatest savings and benefits.

HMOs themselves are less than enthusiastic about the MSA approach, especially to the extent that proposed legislation would require catastrophic coverage with high deductibles. Under other federal and state laws, HMOs are precluded from demanding large deductible payments. Indeed, the HMO philosophy is to encourage early attention to medical problems—not to create disincentives to preventive care.

What HMOs and MSAs may have most in common is a market-oriented strategy to reduce aggregate payments to health care providers. As the nation continues to rely on a pluralistic health care system, both approaches are likely to obtain, and evolve under a fair market test.

**Assessing New Jersey insurance reforms.** In a report funded by the Kaiser Family Foundation, the Brandeis University-affiliated Institute for Health Policy Solutions has reviewed New Jersey's experience under state-legislated health insurance reforms.

In the individual market, the report concludes that "preliminary data indicate . . . a positive impact," with a one-third increase in the number of insureds. The reforms create five standardized indemnity plans, plus a single standardized HMO plan, that must be offered to consumers. Standardization of plans allows for the emergence of a large enough pool of insureds to hold premium costs down to a generally affordable level.

In the small group market, however, involving individuals employed by firms with fewer than 50 workers, analysts found that it was too early to draw solid conclusions.

Besides creating standardization of benefits, the reforms include several other features of interest to the health policy community: penalties for insurers who fail to enroll substantial numbers of consumers in the individual market; a gradual shift toward community rating under which insurers may not alter premium requirements from group to group, based on demographic composition; and a phase-in of the requirement that nonstandardized plans may not be offered to small groups.

What the report writers found most reassuring were a more competitive individual insurance market, the continued participation by many carriers in the small group market, and the retention of insurance by young people who were considered vulnerable to higher premium prices under community rating.

The report also addressed reforms in New York, Minnesota, and California. □ James E. George, MD, JD; Neil E. Weisfeld, JD, MSHyg

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# BOOK REVIEWS

## OCCUPATIONAL ENVIRONMENTAL MEDICINE

Robert J. McCunney, MD. *New York, NY, Little, Brown and Company, 1994.* Occupational medicine is in its infancy as an acknowledged area of medical specialization and an appreciation of the potential importance of its role in the delivery of medical care in our industrialized societies continues to be unacknowledged.

Defining the medical and legal criteria for disease and case detection resulting from occupational hazards often creates major problems and conflicts between participants in the struggle for establishing political agendas, national budgets, and health guidelines. Contributing to such confusion are difficulties not only in the identification of hazardous agents but in clarifying the pathogenesis, dose responses, and threshold limits below that no hazard exists.

This excellent book, *A Practical Approach to Occupational Environmental Medicine, Second Edition*, informs us on all aspects of occupational and environmental medicine. However, for the specialist in occupational medi-

cine, one criticism is that it does not update us to the extent we would expect of a new edition. For example, its suggested texts and references in an otherwise very well-written chapter on pulmonary disease are dated only to 1991.

There are five sections with 50 chapters and six useful appendices on all aspects of identifying, diagnosing, treating, and preventing health hazards in our environment at the workplace and elsewhere in the community and at home. There are 62 contributors.

The great advantage of this book is that it gathers all aspects of occupational and environmental medicine in one text. It provides an overall perspective for health care professionals, especially physicians, whether you are a student, generalist, subspecialist, or educator. It is a worthy feat to accomplish in a well-indexed, 823-page, easy-to-handle paperback at an affordable and most worthwhile price. This text is strongly recommended. □  
Monroe S. Karetzky, MD

## SELECTED TOPICS IN THE CLINICAL SCIENCES

Palo Alto, CA, *Annual Reviews, Inc., 1995.* This repeat performance of *Annual Review: Selected Topics in the Clinical Sciences* merits the similar kudos that were accorded last year's issue. The subject matter is representative of the major fields of internal medicine that are experiencing newer understanding from the standpoint of diagnosis and treatment as well as from the surgical modalities that have application in the general field of internal medicine. Currently applicable findings from the molecular-genetic laboratories in the areas of both oncologic and

degenerative diseases are addressed.

Chapters are identified by subject and author in the table of contents and by an additional category list. Articles are followed by copious lists of literature citations and preprint and reprint services are available in addition to e-mail. Illustrations are sparse and simple in detail but adequate. Abstracts precede each chapter as well as key words. The physical aspects of the volume make for ease of briefcase portability and the text for easy readability. □ Pasquale A. Ruggieri, MD

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# LETTERS AND VIEWPOINTS

## HEPATIC NECROSIS

A 46-year-old white female was seen for persistent symptoms compatible with allergic rhinitis complicated by a bacterial sinusitis. The patient had not responded to intra-nasal steroids in the past and was allergic to penicillin; she had tolerated cephalosporins. She had a history of mild hypertension and of mitral valve prolapse treated with one-half tablet of atenolol and chlorthalidone (Tenoretic®) a day. There were well-verified normal liver tests since 1989, using yearly SMAC testing; the last test was performed six months prior to this illness. The patient was treated with a ten-day course of loratadine—10 mg/day and cefprozil 250 mg TID. Within 48 hours after starting the medications, the patient's urine turned a dark orange color and she felt achy, but was breathing better. On the last day of therapy, the patient noted yellow-colored eyes.

Laboratory tests were consistent with a severe hepatitis, the SGOT rising to the 2,000 range, bilirubin rising to the low 20s and prothrombin time rising into the upper 20s, which did not improve with vitamin K. All autoimmune and infectious workup was negative including: antibody testing to hepatitis A, B core antigen, C, and Delta. Hepatitis C by PCR

was negative twice over six weeks. Hepatitis B surface antigen was negative. Antibody to CMV was positive IgG only 1:74 (N1. >00-.90). Antibodies to coxsackie virus and echovirus were negative. Antibody to mycoplasma was negative. Ceruloplasmin was 26 (N1. 21-53). Serologies including ANA, anti-smooth muscle antibody, and anti-liver/kidney microsomes were all negative. About six weeks later, a liver biopsy was performed using direct visualization via laparoscopy and subacute hepatic necrosis was verified, with nodular regeneration and probable early evolution to cirrhosis. This biopsy report also was confirmed at the liver transplant center. The patient, despite severe liver dysfunction, remained surprisingly asymptomatic, but developed ascites and edema. Her ammonia rose and she became encephalopathic after a brief course of prednisone. She was referred to a liver transplant center two months after the onset of her liver disease, and underwent a successful liver transplant. The liver transplant center also felt this irreversible hepatic necrosis was due to loratadine. She is doing well four months after her transplant.

I could find no reported cases of liver toxicity associated with

loratadine in the literature despite the warning in *Physicians' Desk Reference (PDR)* of rare spontaneous abnormal hepatic dysfunction including hepatitis, jaundice, and hepatic necrosis noted in clinical trials involving 90,000 patients. *The Medical Letter* review of loratadine makes no note of hepatic adverse side effects. The FDA has issued no warnings of this type of reaction occurring with loratadine. A computer search revealed no reported cases of hepatic necrosis associated with cefprozil. *PDR* notes elevation of liver enzymes and rare cholestatic jaundice associated with cefprozil as with other cephalosporin antibiotics and penicillin.

There was no other explanation for this rapid onset of irreversible hepatic necrosis with only ten days of medication except for an adverse drug reaction. This may be the first reported case of such a reaction in the medical literature.

Practitioners who commonly prescribe these medications should be aware of the possible rapid and irreversible nature of this drug reaction after a short course of medication. Further investigations are warranted in view of the life-threatening nature of this unpredictable reaction. □ James S. Najarian, MD

## ORAL CONTRACEPTIVES

It has come to my attention, through the medium of a marketing agency hired by one of the largest manufacturers of oral contraceptives (OCs) containing desogestrel, that my support of OCs containing desogestrel as expressed in "A practical guide for prescribing birth control pills" (*NJ MED* 91:393-395, 1994) be retracted.

Recent information, unpublished in the United States, suggests an increased incidence of thromboembolism among users of OCs containing desogestrel. Consequently, the prescriptions and use of such OCs should be discontinued, probably not in the middle of a cycle for nonsmokers.

Incidentally, I have been unable to find any long-term

studies of the allegedly beneficial effects of the lipid-neutral OCs on lipid profiles.

I would appreciate any readers apprising me of this information. □ Jerome Abrams, MD

## TAKING ESTROGENS

I read with interest the succinct review article on taking estrogens (*NJM* 92:580-582, 1995) by Dr. Abrams.

I offer a different opinion regarding the value of bone densitometry. Most authors agree that bone densitometry using dual energy x-ray absorptiometry (DEXA) is an accurate and nonin-

vasive method of assessing bone density. Without such information, it would be truly difficult to guide the management of osteoporosis since it is impossible to do as Dr. Abrams suggests: that is, is to make the diagnosis of osteoporosis with a two-second glance.

Furthermore, DEXA scanning is significantly more sensitive,

less expensive, and of lower radiation exposure when compared to quantitative CT scanning. In our practice, we have used this technique with a great degree of patient satisfaction. We have obtained valuable clinical information that has been irreplaceable.

□ Michael M. Rothkopf, MD

## THE FUTURE OF HEALTH CARE

In the article, "The future of health care and medical profession in the United States" (*NEW JERSEY MEDICINE* 92:667-669, 1995), Dr. Louria boldly developed a number of concepts, three of which can be considered very controversial.

The first is a single-payer system by which we may presume Dr. Louria means a government-controlled system ordinarily given the stigmatized designation, "socialized medicine." He, like many other doctors today, is opting for the lesser of two evils—government control versus dehumanizing control (for both patients and physicians) of the managed care system of commercialized medical care. Perhaps, he is correct that America eventually will go the way of the other major countries of the world and consolidate the

present patchwork of health care into a single system.

The second projection is more stringent health care rationing, not like the present passive, ill-defined, and mainly managed care-directed activity, but as an explicit, predominantly age-determined policy; such a policy is antithetical to the American societal medical expectations of today. Will these expectations change? Given our past medical experience that is highly doubtful.

Finally, a daring foray into "assisted dying" as part of our future ignores the present legal environment and the legitimate concerns of many religions. Years ago, before the present technological "successes" and the legal morass in which we labor, patient, family, and physician would agree that to prolong life was, if not cruel, at

least useless. Physicians felt comfortable with using "benign" neglect, to avoid extraordinary means to allow the patient to die with dignity and comfort. Benign neglect was the informal predecessor to today's living will. The term "assisted dying" implies an active interference with nature and the natural processes to achieve a finale. This is not only very undesirable to many people and physicians who can envision abuse and a desertion of the Hippocratic oath, but would require a change in our legal environment.

It appears as though Dr. Louria has predicted a possible health care future that defies predictability as much as life itself. □ F. Peter Rescigno, MD

## HEALTH CARE'S FUTURE

As you encouraged comments relative to Dr. Louria's article, "The Future of Health Care and the Medical Profession in the United States," which appeared in the October issue of *NEW JERSEY MEDICINE*, I am writing this note.

Dr. Louria's article is without doubt the finest, the most definitive, and the most greatly needed presentation of the present deficiencies and the future problems of the practice of medicine. It should be read by every physician, medical student,

and hospital administrator. The goals and strategies detailed in the article must be recognized by all. □ Rufus R. Little, MD



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# EDITOR'S DESK



## OCCUPATIONAL MEDICINE

Occupational medicine, the effect of work on health and health on work, is a part of the more encompassing field of environmental medicine, which we explored in *NEW JERSEY MEDICINE* in the special issue of October 1994.

In that issue, I wrote, "Environment—the aggregate of surrounding things, conditions, or influences, especially as affecting the existence or development of someone or something. One synonym for environment is 'living condition,' which seems appropriate for this special issue where the authors are concerned about the protection of the individual from his surroundings." These words, of course, apply equally well to the subject of occupational medicine or health.

We also noted previously how specific external forces have influenced health. We touched upon some of the subtle ways in which the environment has produced illness and injury.

Now Dr. Gochfeld and his fellow contributors are showing you some of the hazards confronting the worker in New Jersey—including diseases resulting from airborne contaminants, mechanical, chemical, and biologic agents, and stresses. My focus shall be more limited. I shall touch briefly on a few of the hazards affecting us as physicians in our workplaces. In most instances, we have problems common to other workers, but sometimes we do not recognize them or we tend to minimize them.

Violence is a fact of life in the American scene. It may seem more prevalent and more indiscriminate today, but it has been a part of our history from the beginning of this country. President John F. Kennedy re-

ferred to our "dangerous and untidy world." From 1980 through 1989, occupational homicides were the third leading cause of death in the workplace, and the number one cause of death for women. It is not just police officers, bartenders, cabbies, postal workers, or drug dealers who are targets; unfortunately, physicians also can be singled out. Psychiatrists and emergency department workers may have special risks, but we all must be wary of the potential for violence. The National Institute for Occupational Safety and Health (NIOSH) reported that 26 physicians were victims of homicide from 1980 through 1990.

NIOSH also reported the deaths of 13 physicians during the same period that were due to motor vehicle accidents considered work related. A few of us may have firsthand knowledge of some of these fatalities. Many more of us know of near misses, some with severe injuries, in ourselves or in close friends and colleagues. The causes are manifold: some are associated with alcohol or other drugs, some with foolish and unnecessary careless driving, and many are due to a combination of fatigue and a physician's sense of responsibility toward real or imagined emergencies. But they exist. As a helpful hint—statistics have shown that speeding above legal limits, because of a supposed emergency, does not save lives, except in the case of poisonings. So throttle it down; the life you save may be your own.

Other physical ailments afflict the physician in ways similar to people in other occupations. Back injuries, hernias due to lifting or controlling patients, carpal tunnel problems associated with re-

petitive actions, burns, and dermatitis from contact with thermal, corrosive, or irritating materials—these are not unique to us. We also do not constitute the only group that can contract bacterial and viral diseases from those around us. However, we are at greater risk because we minister to the sick. But we should be aware of the possibilities and protect ourselves in appropriate fashion. There is no excuse for failure to be immunized against the common pathogens of the area, including influenza, hepatitis, and various types of pneumonia. Many years ago this writer suffered from what then was called serum hepatitis, ascribed to a needle stick in the operating room. I was not able to protect myself at that time; vaccines were not available.

A widely disseminated report in the media this past Thanksgiving put the risk of HIV in young American men at 1 in 92. The ratio varies with ethnicity, but there is no group without risk. In January 1995, the Centers for Disease Control declared that in 1993 AIDS had become the number one killer of adults from ages 25 to 44.

The increasing problem of HIV infection is complicated by the strange politics associated with its control. It seems to be the only infectious disease not handled as a public health problem. Some years ago the MSNJ House of Delegates asked that there be "universal" testing for the virus. (The word "mandatory" had been rejected.) Nothing has happened since then that has made it easier to identify people who present a risk to their contacts, except for blood donors. Yes, there are cogent arguments on both sides of the testing issue, and we are



unable to convince people to think and act logically and compassionately to prevent discrimination, but where lies the greater obligation? Solomon had it much easier; the life of only one baby was in jeopardy.

There no longer should be any disagreement regarding the direction taken by this infection. It goes from the patient to the health care worker. Patients do give AIDS to those who minister to them, nurses constituting the group most vulnerable. We also are on the firing line, but are rather cavalier about our dangers. Nurses and other nonphysician caregivers are given training regarding primary, secondary, and tertiary protection, including physical barriers and universal precautions. When my dental hygienist checks my neck for enlarged nodes and when phlebotomists make their rounds, they wear plastic gloves. So do many others in the hospital environment. But not physicians. Why not? Are we immune? Are our life expectancies higher than the rest of the population? Are we not only being foolhardy, but also failing to provide leadership for others? And should not we be aware that new pathogens and different strains of old ones pose additional hazards requiring continuous carefulness and preparation?

In November 1995, in the issue of *NEW JERSEY MEDICINE* celebrating the centennial of the discovery of x-rays, I suggested that the medical profession still had not learned the lessons it should have from the morbidity and mortality suffered by the early martyrs in the field of roentgenology, and by the damage done to the subjects of experiments whose potentials were not understood or ignored. Enough said. I hope the advice given previously will be taken seriously.

It also is understood that the physician is no stranger to the effects of stress. With apologies to Shakespeare: have we not "hands,

organs, dimensions, senses, affections, passions; fed with the same food, hurt with the same weapons, subject to the same diseases?" We are fortunate not to be strapped with dull, dead-end jobs that numb the soul and paralyze the will. But the adventure and challenge of medical practice produce stresses unknown by the average worker. There was nothing so carefree and exhilarating as being a chief resident, with freedom of decision and lack of final responsibility; there was always backup. But then came the cold, cruel world—where consultations helped, but, as Harry indicated, the buck stopped where the decisions were made.

Add the temptation to relieve the tension with martinis or worse, and you have one of the reasons why the percentage of impaired physicians approximates that of the rest of the population. Then juggle the responsibility to the patient with the responsibility to spouse and children, and the potential psychic damage to all, including the doctor, becomes evident. As I mentioned in a previous missive, the numbers and percentages of physicians needing and seeking psychiatric help continues to climb. Will the 9 to 5 doctor under managed care be able to trade initiative and independence for financial and psychic stability? Or will we lose our *raison d'être*, as has happened for so many in the dead-end jobs mentioned above? Some programs are being developed to aid in coping such as one in Genesee Hospital in Rochester, New York; five primary areas were addressed: self-awareness, sharing of feelings and responsibilities, self-care, developing a personal philosophy, and developing sensible limits and nontraditional coping skills. Other sources are available, including a model one of work stress management in Finland, referenced in *Occupational Medicine, 3rd Edition*, by Mosby-Year Book, Inc. (1994).

We have written in the past about Bernardo Ramazzini, father of occupational medicine, who added an important question to the medical history-taking: "What is your job?" This concept is expanded in *The New England Journal of Medicine* of October 25, 1995, where Dr. Lee Scott Newman gives those of us who are less than expert in this discipline an excellent primer on the approach to the "recognition of illness caused by occupational exposure." We can all learn from it, but, under managed care, the "primary care physician" will be expected to become an expert and to bear the responsibility for treating these illnesses and injuries. I hope this special issue, along with other sources, will be of help. Thanks to all our authors.

Finally, in a somewhat lighter note, a column by Rick Malwitz in *The News Tribune* of September 30, 1994, entitled "Something smelly in New Jersey," tells of the horrible occupational hazard posed to the environment by baked bread. It seems the wonderful aroma is related to the emission of ethanol, a "dreaded volatile organic compound." In order to comply with the Clean Air Act of 1990, scrubbers must be used by commercial bakeries to turn the dangerous ethanol into carbon monoxide. So out with the bakery smell. Fortunately, we can compensate with the delightful odor of oxygenated gasoline. □ Howard D. Slobodien, MD

*That which is not good for the  
beehive cannot be good for the bees.*

Marcus Aurelius,  
*Meditations*, 2nd century

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Here's a typewriter, here's a stencil,  
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Ogden Nash,  
*The Primrose Path*, 1935



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# GUEST EDITORIAL

## OCCUPATIONAL MEDICINE

We divide our lives between our home, the workplace, and other places in the environment where we travel, shop, and play. Adults spend nearly one-third of their lives at work, and for many people who work overtime or second jobs or who must take work home, employment probably consumes more than one-half of the waking hours. It is little surprise, therefore, that work affects health, and good health is an important ingredient for safe and productive work.

Historically, New Jersey has been the most heavily industrialized state in the nation. Even today it has a greater proportion of its workforce engaged in manufacturing than any other state. Its long history of heavy industry, with an emphasis on chemicals, petroleum, and pharmaceuticals has conferred many benefits, but has left New Jersey with the unfortunate legacy of having many hazardous waste sites. In New Jersey, the potential for occupational and environmental exposure to hazardous substances go hand in hand.

As the economic and social climate has changed in the last few decades, the service sector has gained prominence in New Jersey. Here, too, workers encounter potential hazards. One of New Jersey's growth industries, for example, is hazardous waste remediation. Indeed, New Jersey ranks number one in the number of Superfund sites. As the most densely populated state in the nation, New Jersey has a high number of people living near, or even on, former industrial sites. It is no surprise, therefore, that New Jersey has taken a leading role, nationwide, in the recognition and prevention of environmental and occupational hazards.

New Jersey's unique attributes require it to pay rigorous attention to hazardous conditions in the home, community, and workplace environments, and it is not surprising that New Jersey has been a leader in environmental and occupational regulations to protect its population.

New Jersey has more than its share of occupational physicians, experts to whom clinicians can refer patients when a work-related problem is recognized or suspected. This special issue of *NEW JERSEY MEDICINE* focuses on occupational health and its importance to clinicians in other specialty areas or clinicians in primary care. This issue emphasizes the relevance of a patient's work to the evaluation and management of medical conditions. Except for pediatricians and geriatricians, most patients are employed, and physicians must consider how employment may affect health and vice-versa.

In principle, occupational diseases are completely preventable. The field of industrial hygiene focuses on the recognition, evaluation, and prevention of hazardous workplace exposures. Control strategies can be divided into engineering controls and administrative controls. Engineering controls include the substitution of less hazardous chemicals and processes, improving the ventilation, enclosing hazardous processes, or using protective equipment. Administrative controls include the implementation of right-to-know and providing information and training to workers and supervisors. Regular monitoring of the workplace environment through air sampling and periodic medical surveillance examinations also are used to estimate exposure and focus preventive efforts.

When these controls are not invoked, workers who are exposed to and harmed by chemical, physical, or biological hazards at work, are eligible for workers' compensation. This insurance system provides for medical expenses and lost wages. It is intended to be a no-fault system. The worker can be compensated regardless of the extent to which he was at fault, while the employer's liability is limited, regardless of how negligent the employer may have been. Contrary to opinion, employers support workers' compensation legislation to protect themselves against liability judgments.

To be eligible for workers' compensation, a worker must show that he was exposed to the hazard and that he was harmed. It is not necessary that the exposure was the sole cause of illness, since a worker is eligible for compensation if the exposure accelerated a disease or aggravated a pre-existing condition. In the case of an accident causing a physically apparent injury, access to compensation is relatively straightforward, but in the case of occupational diseases caused by workplace exposure, it often is difficult to demonstrate causation, acceleration, or aggravation, and a great amount of health care costs that should be borne by the compensation system are shifted to the general health insurance pool.

This special issue focuses on a variety of occupational medicine challenges. We have selected papers that comment on the magnitude of occupational disease and papers on diseases resulting from environmental hazards. □ Michael Gochfeld, MD, PhD; Joan Leonard Hudgins, MD; and Monroe Karetzky, MD, guest editors



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# Occupational medicine in New Jersey: Who can help?

Michael Gochfeld, MD, PhD

*Occupational medicine information and data are available from main sources at the New Jersey State Department of Health (DOH) Occupational Health Program, the New Jersey Poison Information & Education System, and the University of Medicine and Dentistry.*

**T**he primary care physician is the frontline resource for most occupational medicine problems. With a modest expansion of history taking, most practitioners

will recognize hazardous exposures their patients encounter at work.

If patients work in the private sector, access to information about workplace hazards is as-

sured by the OSHA Hazard Communication Standard, which requires employers to provide workers with material safety data sheets on the substances handled. Although these sheets vary in the quality of the information they provide, they offer a starting point for identifying specific hazards in the workplace. Employees in the public sector have similar protections under New Jersey's *Right-To-Know Act* and under the *Public Employees Occupational Safety and Health Act*.

Federal and state acts guarantee workers protection from harassment or reprisal for invoking the Act and requesting information. Nonetheless, employees may be reluctant to exercise their rights. However, employees may have other means of accessing information regarding products.

Clinicians can turn to other experts for assistance: the Occupational Health Program of the New Jersey State Department of Health (DOH), the New Jersey Poison Information & Educational System, and the occupational medicine experts at the University of Medicine and Dentistry of New Jersey. The Association of Occupational and Environmental Clinics (AOEC) is a national network of clinics and clinical specialists in this field who provide clinical and consultative services (Table 1). In addition, there are many providers of occupational medicine services in the telephone yellow pages.

**Table 1. Occupational medicine resources in New Jersey.**

- New Jersey State Department of Health  
Occupational Health Program—609-984-1863
- New Jersey Poison Information & Educational System—201-926-7443  
Steven Marcus, MD, Richard Shih, MD
- Occupational Safety and Health Administration Regional Offices  
Avenel—908-750-3270      Marlton—609-757-5181  
Parsippany—201-263-1003      Hasbrouck Heights—201-288-1700
- Association of Occupational and Environmental Clinics—202-347-4976
- American College of Occupational and Environmental Medicine  
708-228-6850, FAX 708-228-1856
- UMDNJ-Environmental & Occupational Health Sciences Institute  
Clinical Center—908-445-0123
- UMDNJ-Northern New Jersey  
Leonard Gorkun, MD—201-982-2500  
Lawrence Budnick, MD—201-982-4812
- UMDNJ-Central New Jersey  
Howard Kipen, MD—908-445-0182  
Iris Udasin, MD, Michael Gochfeld, MD,  
Sandra Mohr, MD—908-445-2917
- UMDNJ-Southern New Jersey  
Marilyn Howarth, MD—609-342-2489  
Elissa Favata, MD—609-751-5455



**Table 2.** *Distribution of board certification among New Jersey members of the American College of Occupational and Environmental Medicine (n = 273).*

Specialty Area	n	Percent
Boards in occupational medicine (OM)	48	18
Certified in OM and another ABMS specialty	29	11
Boards in internal medicine (IM) as well as OM	29	9
Boards in IM only	58	21
Boards in family practice only	34	12
Boards in emergency medicine	14	5
Boards in surgery	7	3
Boards in public health	5	2
Boards in orthopedic surgery	5	2
Not boarded in any specialty	96	35
Various other boards include pediatrics, anesthesiology, and physical medicine.		

**Table 3.** *Employment distribution of all New Jersey American College of Occupational and Environmental Medicine (ACOEM) members (1993-1994) and those with occupational medicine (OM) boards.*

	ACOEM Members	OM Boards	Percent
Government	1	1	100
Academia	11	6	55
Corporations	119	30	25
Private consultants	23	5	22
Hospitals	13	1	8
Industrial medicine groups	26	0	0
Multispecialty groups	27	0	0
Emergency services	8	0	0
Residents (trainees)	5	N/A	N/A
Retired	39	5	13

A physician board certified in occupational medicine is an important resource. Of the 40 residency training programs in occupational medicine, 2 programs are located in New Jersey: at Robert Wood Johnson Medical School and at Morristown Memorial Hospital (in conjunction with Columbia University). Training in both programs encompasses environmental and occupational medicine. To become

board eligible, physicians must complete three years of training including a standard PGY-1 (usually in medicine or family practice), an academic year leading to a master's degree in public health, and a practicum year gaining hands-on experience recognizing, treating, and preventing occupational health problems. Most training programs require that entering residents have completed at least two or three years

of PGY training.

Board certified occupational physicians are trained to place a heavy emphasis on the recognition and prevention of workplace hazards, but many physicians in the field have other training. In the 1993-1994 directory of the American College of Occupational and Environmental Medicine, 273 members list addresses in New Jersey. Table 2 shows the board certifications held by these members. Forty-eight members held boards in occupational medicine (18 percent), while 82 members held boards in internal medicine (30 percent). Ninety-six members (35 percent) held no boards in any discipline.

Of the 48 board certified occupational physicians, 60 percent held boards in a second specialty, mostly internal medicine. Many of the services provided to employers related to emergency treatment of injuries, and some of these services are provided by emergency centers. Fourteen members held boards in emergency medicine and 7 members also held boards in family medicine or internal medicine or surgery, but none held boards in occupational medicine. Physical medicine and orthopedics were less well represented, which is surprising considering the important role they play in evaluating, treating, and rehabilitating injured workers. The board certified physicians were employed in industry, academia, and in private consulting. Table 3 shows the proportion of physicians practicing in different settings who are board certified. ■

Dr. Gochfeld is guest editor of this special issue. Dr. Gochfeld is affiliated with the Department of Environmental and Community Medicine, UMDNJ-Robert Wood Johnson Medical School. He is a member of the Occupational Health Division of the Environmental and Occupational Health Sciences Institute (EOHSI). Address reprint requests to Dr. Gochfeld, EOHSI, 681 Frelinghuysen Road, Piscataway, NJ 08855-1179.

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# A selective overview of occupational psychiatry

Daniel P. Greenfield, MD, MPH, MS  
Jeffrey A. Brown, MD, JD, MPH

*In the current environment of ever-changing medical and psychiatric care, the authors provide a selective overview of occupational psychiatry from the perspectives of clinical and consultative activities; preventive medicine and epidemiologic aspects; administrative and ethical issues; and future trends.*

**P**sychediatric problems arising in the workplace are associated with complex interacting relationships that may confuse physicians attempting to deal with these problems.

This article will provide a selective overview of the field of occupational psychiatry from four perspectives: clinical and consultative activities in occupational psychiatry; preventive medicine and epidemiologic aspects of occupational psychiatry; administrative and ethical issues in occupational psychiatry; and future trends in occupational psychiatry.

## CLINICAL AND CONSULTATIVE ACTIVITIES

Occupational psychiatry has been defined as "the area of psychiatry concerned with mental illness in industry, including the psychiatric aspects of absenteeism, vocational adjustment, operational fatigue, and accident proneness,"<sup>1</sup> incorporating "prevention and positive health maintenance."<sup>2</sup> Areas of clinical activity in occupational psychiatry include the evaluation and treatment of the following areas as they impact on employees' workplace performance: major traditional

psychiatric disorders, stress-related disorders, related family problems, substance abuse disorders and issues, evaluation for toxic (especially neurotoxic) exposures, and other psychological problems.

Psychiatric involvement in the workplace can include consultation and evaluation of patients/employees for a variety of reasons, including fitness to start or resume work, "placement, work prognosis, disability, causality, or compensation,"<sup>3</sup> e.g. workers' compensation evaluations. In this respect, the role of the occupational psychiatrist—whether as an employee of the organization or as an outside consultant—is similar to that of any physician consultant. The role is to perform a clinical evaluation, with review of records, interview/examination of the patient/employee with applicable testing (including psychological screening, with referral for psychological and neuropsychological testing, if indicated), and referral for additional consultation and testing, if indicated. In the occupational/environmental psychiatry context, the clinical evaluation also should "identify symptoms and their time course, iden-

tify potential exposures, and identify risk factors."<sup>4</sup>

In our experience, the role of the occupational psychiatrist as a treating physician of employees/patients is limited. Because organizations often provide employees with mental health benefits—whether health insurance, HMOs, or inhouse EAPs<sup>5</sup>—these benefit programs often will be the ways in which psychiatric/psychological treatment and counselling are provided, with recommendations for treatment/counselling made by the occupational psychiatrist in a consultative and referral capacity. In addition, the occupational psychiatrist often is called upon to followup on treatment recommendations and to supervise inhouse counseling, e.g. by EAP counsellors.

In summary, the clinical role of the contemporary occupational psychiatrist relies on the psychiatric clinical knowledge and experience of the practitioner. However, this role also requires that the practitioner be aware of the epidemiologic and public health aspects of the workplace as a system and that the practitioner functions more as a consultant and supervisor than as an actual hands-on provider of psychiatric care.<sup>6</sup>

## PREVENTIVE MEDICINE/EPIDEMIOLOGIC ASPECTS

Psychiatric and neuropsychiatric disorders have been recognized by the National Institute for Occupational Safety and

Health (NIOSH) as being among the ten most important categories of occupational illness.<sup>7</sup> The broad range of these disorders can be considered as either biologically or psychologically based (or neuroscientific or psychosocial), or a combination of these two disorders.<sup>8</sup> They may include the broad and complex range and interactions of traditional major psychiatric disorders, chemical dependency disorders, toxic exposures,<sup>6,11</sup> stress-related disorders,<sup>9,10</sup> and others.

In this context, the occupational psychiatrist should incorporate the orientation of public health/preventive medicine physicians toward such activities as case finding, health promotion and disease prevention, medical monitoring, workplace surveys, toxic exposure assessment (industrial hygiene), accident prevention, and other preventive aspects of medicine and psychiatry.<sup>11</sup> The epidemiologic concepts of primary ("prevention of disease by altering susceptibility or reducing exposure for exposed individuals"), secondary ("the early detection and treatment of disease" in preclinical and clinical stages of disease), and tertiary ("the alleviation of disability resulting from disease and attempt to restore effective functioning" in the stage of advanced disease or disability) levels of prevention<sup>12</sup> apply very well to this aspect of occupational psychiatry; by applying these concepts to traditional areas of psychiatric intervention and treatment (such as major psychiatric disorders, substance abuse, workplace and stress, toxic exposures, and others), the occupational psychiatrist is in a position to serve both patients/employees and management in a broad-based and cost-effective way.

## ADMINISTRATIVE AND ETHICAL ISSUES

Recognizing the inevitable tension between a physician's responsibility to patients/employees

on the one hand and the employer (management; the company) on the other hand, the American College of Occupational and Environmental Medicine has addressed that question in its Code of Ethics.<sup>4</sup> This Code of Ethics places responsibility on the occupational physician (regardless of the practice setting) for preventing illness, protecting the patient/employee, and maintaining confidentiality.<sup>4</sup> In psychiatric practice, the importance of this last area of responsibility is particularly important by virtue of the highly confidential and often sensitive nature of the information obtained under the umbrella of the doctor-patient treatment relationship. Any occupational psychiatrist providing clinical (especially treatment) services should be sharply aware of this fact, and should distinguish treatment/supervision activities from consultation/evaluation activities. Although treatment/supervision activities are more clearly protected by doctor-patient confidentiality, or privilege, than are evaluation/consultation activities, the latter also may be subject to degrees of confidentiality, for example, in providing only information relevant to the consultation/evaluation activity.<sup>4</sup> Again, in occupational psychiatric practice, the importance of maintaining confidentiality should not be underestimated.

In the area of consultation/evaluation activities, the occupational psychiatrist and company management should be careful to distinguish among clinically oriented questions (such as diagnosis and illness prognosis) and administratively oriented questions (such as fitness-for-duty, return-to-work prognosis, disability and compensation issues, and cause-and-effect relationships between workplace conditions and psychiatric symptomatology and disorders). Management should frame questions carefully, and the occupational psychiatrist—using a preventive medicine systems or-

ientation—should assist management in that framing, especially in situations in which an exposure<sup>13</sup> (or even an imagined exposure<sup>14</sup>) affecting more than one patient/employee is in question. Upon completing the consultation/evaluation, the occupational psychiatrist, in turn, should provide management with a preliminary oral and comprehensive written report, responsive to the questions that led to the consultation/evaluation, sensitive to confidentiality issues, and capable of being used in courts, unions, and other administrative and forensic contexts. Rigaud recommends the following elements be included in an occupational psychiatry consultation/evaluation report: reasons and questions that promoted the referral; problems reported by the patient/employee; summary of significant data gathered from occupational, medical-surgical-psychiatric, and familial-social-economic histories; findings of the clinical interview and mental status examinations; opinion, including diagnoses and prognoses using the multiaxial DSM-IV<sup>15</sup> nomenclature system and occupational and therapeutic recommendations; and specific suggestions for placement and additional measures.<sup>3</sup>

## FUTURE TRENDS

Like every branch and specialty in medicine, and like its parent, general psychiatry, occupational psychiatry exists in a world of public dissatisfaction with rising health care costs, disenchantment with many aspects of health care, and increasing emphasis on cost containment and managed care.<sup>16</sup> Occupational psychiatry, like many other areas of health care, will face decreasing direct funding, e.g. for staff positions in employer organizations and companies, and will have to continue to develop alternative models for delivery systems. Such models, as is the case for medical practice in general, include free-standing occupational and industrial medical



practices providing a mixture of contractual, e.g. PPO, and fee-for-service psychiatric services for client organizations and companies; group practices; divisions of hospitals; and unique partnerships among physicians and health care organizations, such as physician hospital organizations and HMOs.

CONCLUSION

In the current environment of changing medical and psychiatric care, and of changing organizational and business structures and climates, the effective occupational psychiatrist should be a unique individual, combining the talents and expertise of an astute psychiatric clinician, a knowledgeable preventive medicine specialist and epidemiologist, and a skilled administrator able to balance the ethical dilemmas of divided loyalties as both the "company man" and the "patient/employee man."<sup>17</sup> Such talents and expertise go beyond the traditional clinical training and experience of a psychiatrist and an occupational medicine specialist. To be truly effective in a role requiring an individual and a population medicine orientation, the occupational physician/psychiatrist should combine all of these skills. ■

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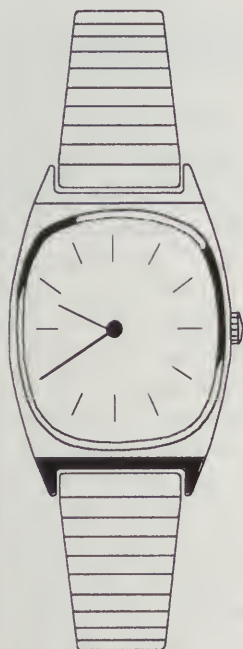
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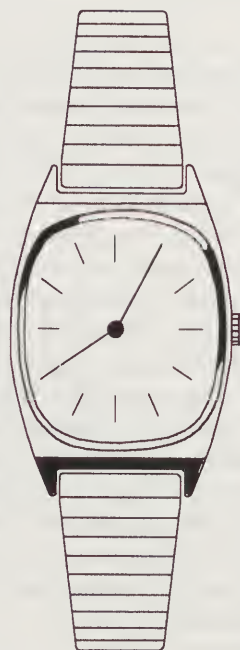
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pain in your right  
arm and side ...



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heart attack ...



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# A study of occupational asthma in New Jersey

Joan F. Leonard Hudgins, MD  
Monroe S. Karetzky, MD

*Exposure to causal agents of asthma is occurring with increasing frequency in the workplace. Awareness of these agents will alert the physician to the sentinel case, the need for surveillance and avoidance, the most effective therapy, and prophylaxis.*

Clinical data have indicated that asthma may be increasing in incidence and severity. Various factors have been proposed to be responsible for these phenomena, especially in the area of workplace environmental air pollution causing occupational asthma, the most common, occupationally related respiratory ailment.<sup>1</sup> The increase in occupational asthma has been attributed to an expanding knowledge of the problem as well as an increase in the number of chemicals capable of causing occupational asthma.

Occupational asthma is a variable airway narrowing caused by inhalation of a sensitizing concentration of dusts, fumes, vapors, or gases in the work environment that accounts for 2 to 15 percent of all asthma.<sup>2</sup> The pathogenesis involves airway inflammation, mediator release, bronchial hyper-reactivity, and bronchoconstriction similar to asthma associated with nonspecific stimuli. However, a specific causal agent or setting is identified in occupational asthma. The strict definition of occupational asthma excludes pre-existing asthma that is exacerbated by work-related ex-

posure. The diagnosis of occupational asthma is made when there is evidence of asthma causally related to a work exposure. The importance of recognizing the relationship is that occupational asthma may be cured by early diagnosis and removal from the inciting agent. The prognosis of occupational asthma and the probability of persisting disease is directly related to the duration of exposure before and after the onset of symptoms.

## PRESENTATION AND EPIDEMIOLOGY

Occupational asthma is distinct from such conditions as hypersensitivity pneumonia, toxic inhalation, reactive airways dysfunction syndrome (RADS), and acquired variable airway obstruction due to the inhalation of high concentrations of nonspecific irritant substances.<sup>3,4</sup> Byssinosis, reversible airway obstruction caused by textile dust exposure, also is not considered to be occupational asthma. A subject's response to inspired particles or extrinsic antigens depends upon the existing state of airway and immunological reactivity. An asthmatic may develop signs of airway narrowing when exposed

to any irritating dusts or fumes, but this is attributable to reflex bronchoconstriction from pre-existing airway hyper-reactivity rather than to an acute allergic response. Nonspecific irritants such as subtoxic exposure to sulfur dioxide, smoke, and exertion in cold or dry air, which are not causally related to the airway hyper-reactivity of the asthmatic state, must be differentiated from specific triggers and sensitizing agents. Recently, a classification has been set forth of inhalant reactions into nonimmunological and immunological categories; the latter into immunosuppressive or hypersensitivity types: immediate, delayed, cytotoxic, or immune-complex responses.<sup>5</sup>

Occupational asthma may present with dyspnea, chest tightness, wheezing, or cough. Diagnosis requires objective evidence of a reversible airway obstruction or bronchial hyper-responsiveness. Once the presence of asthma is determined, the causal association with the work environment must be sought with history and work exposure evaluation. There must be a time at work for sensitization to have occurred, i.e. with isocyanates. Usually there is a latent period of exposure for sensitization to evolve, varying from days to months to years, before the appearance of symptoms. Once sensitized, however, brief exposure to a minute quantity of the offending agent may initiate the clinical syndrome of asthma.<sup>6</sup>

**Table 1. Etiologic agents.**

<b>Etiological Agent</b>	<b>Industry/Worker</b>
<b>Low-Molecular Weight</b>	
Toluene diisocyanate	Polyurethane
Phthalic anhydride	Epoxy resins
Western red cedar	Construction/carpentry
Platinum	Platinum refining
Nickel	Metal plating
Penicillins	Pharmaceutical
Colophony	Electronics
<b>High-Molecular Weight</b>	
Grain dusts	Grain handlers
Flour	Bakers
Green coffee beans	Coffee workers
Biological enzymes	Pharmaceutical
Insects	Entomologists
Avian protein	Pet shop workers, pigeon breeders

There are three response patterns: early response, late (delayed) response, or dual response.

An early response has its onset from 2 to 9 hours following exposure with resolution after more than 24 hours accompanied by persistent circadian exacerbations (nocturnal asthma). Thus, late reactions may occur following completion of the workday and may recur for several days. The presence or absence of symptoms such as deterioration or improvement over weekends or during vacations is not in itself a satisfactory index for diagnosis.<sup>7</sup> Moreover, once sensitized, exacerbations may be provoked in nonoccupational settings by nonspecific irritant stimuli. Thus, there may be no diagnostic pattern of deterioration during the working day in many patients. Diagnosis of occupational asthma, therefore, may be difficult because of the potential for an unrecognized temporal association with work exposure. Moreover, persistent bronchial hyper-responsiveness may be evident with nonspecific stimuli such as perfumes, cigarette smoke, cold air, or exercise, making the previous work association obscure.

## ETIOLOGICAL AGENTS

The etiological agents causing occupational asthma are numerous; over 200 chemicals have

been identified.<sup>8</sup> Occupational asthma may be caused by agents that are high-molecular weight compounds, such as enzymes or flour, or low-molecular weight compounds, such as plicatic acid or Western red cedar asthma or toluene diisocyanate. Sample listings of agents are shown in Table 1. Subclassification by molecular weight, the threshold between the two classes being 1,000 Da, has been helpful in noting differences in presentation, risk, and prognostic factors. Atopy is a risk factor for occupational asthma secondary to high-molecular weight compounds, often organic materials, such as animal proteins or enzymes. An IgE mechanism may be more prevalent in workers exposed to high-molecular weight compounds, however, radioallergosorbent testing (RAST) and enzyme-linked immunosorbent assay (ELISA) usually are of little value. Skin tests are positive and airway responses to exposure usually are immediate. Low-molecular weight compounds, usually inorganic chemicals, are more likely to cause peripheral and bronchoalveolar lavage fluid eosinophilia and a late or biphasic response while skin tests are not useful. The mechanism of asthma due to low-molecular weight agents, of which more than 140 have been reported, generally is unknown.<sup>6</sup>

Determination of the type of chemicals used by a worker or others is important. The chemicals used should be known to the worker. Material safety data sheets (MSDS) should be available from the employer. The materials used at a worksite can be compared to lists of agents with a known association with occupational asthma (sensitizers). There has been a growing appreciation of the increasing incidence of asthma due to substances encountered by health care workers in the workplace (Table 2).<sup>9</sup>

## TREATMENT

Though removal from the exposure is essential and can be curative, the longer a worker is exposed to the inciting agent with or without experiencing symptoms, the more likely asthma will persist.<sup>10</sup> The persistence of symptoms after discontinuing exposure also is related to severity of the asthmatic state at the time of diagnosis. Impairment and disability can be minimized by early diagnosis and prompt removal from exposure. Furthermore, continued exposure may result in a fatal asthmatic episode.<sup>11</sup>

Occupational asthma should not be dismissed as an illness that will simply disappear once the worker is removed from the worksite. At least 50 percent of workers developing occupational asthma from exposure to Western red cedar (plicatic acid) continued to have asthma (airway reactivity) 9 to 11 years after removal from the worksite.<sup>12</sup> Long-term followup of patients with IgE-mediated bronchoconstriction also suggests that bronchial hyper-reactivity may not disappear after discontinuing exposure to the inciting agent.<sup>13</sup> The assessment of impairment/disability in patients with occupational asthma should be 1 to 2 years after the cessation of exposure and periodically thereafter since only approximately 1 year of being exposure-free is a plateau in pulmonary function and nonspe-



cific bronchial hyper-reactivity (NSPH) after 2 years.<sup>10,13,14</sup>

The treatment for occupationally related asthma includes the approaches used for nonspecific asthma. If asthma symptoms continue despite removal from exposure or removal is not immediately possible, anti-inflammatory therapy and bronchodilator therapy are indicated. Treatment with inhaled steroids and/or cromolyn is a first-line approach. Bronchodilator therapy with B-sympathomimetics, and if necessary, anticholinergics or methylxanthines also are of potential benefit. Pulse therapy with systemic steroids may be required initially. Immunologic therapy (desensitization) has not been shown to be of value except in isolated reports. It is a misconception that respirators will protect the sensitized worker with occupational asthma. Once sensitization has occurred, small exposures, i.e. leaks, may be all that is necessary to maintain airway hyper-reactivity. Thus, an improper fit or inconsistent wearing of the respirator still exposes the worker to the inciting agent.<sup>15</sup> The use of a respirator also may significantly increase the work of breathing for an asthmatic who is already symptomatic. Complete avoidance of exposure to the agent is the best approach to resolving occupational asthma.

Cigarette smoking often is an associated factor in the setting of occupational asthma and thus smoking cessation is an integral component of a treatment regimen. While the role of smoking is controversial,<sup>16</sup> it has been noted that those who continue to smoke may have accelerated declines in airway function as compared to nonsmokers.<sup>17</sup> Mechanisms proposed for smokers' enhanced sensitization to occupational "asthmogens" range from undefined immunologic effects to include enhanced permeability of the epithelial lining of the bronchial mucosa.<sup>18</sup> However, there is little evidence to support

**Table 2. Occupational asthma in health care.**

Etiological Agent		Location
<b>Low-Molecular Weight</b>		
Formaldehyde		Renal dialysis
Glutaraldehyde		Endoscopy
Hexachlorophene		Wards
Enflurane		Anesthesia
Isonicotinic acid hydrazide		Pharmacy
Ethylene oxide		Surgery
Fixative/developer		Radiology
<b>High-Molecular Weight</b>		
Psyllium		Geriatrics
Pancreatic extracts		Pediatrics
Latex		Surgery
Allergen inhalation		Pulmonary

a thesis that smokers are more predisposed to asthma.

The patient presenting with occupational asthma often is the index case for their worksite. The physician should be alerted to the possibility of other affected workers who are involved in similar duties at the same worksite. A physician, with or without the assistance of an industrial hygienist, should be prepared to "survey" for cases in a susceptible population of workers exposed to agents known to commonly cause occupational asthma. Medical sur-

veillance implies intervention and alteration if not prevention and involves respiratory symptom questionnaires, physical examination, pulmonary function testing, assessment of bronchial responsiveness, and immunological testing. ■

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# Recording occupational Lyme disease in New Jersey

Lawrence D. Budnick, MD

*The author describes a case of occupational Lyme disease and reviews OSHA recording requirements. OSHA states that all cases of occupational Lyme disease be considered occupational injuries, which is inconsistent with medical, epidemiologic, and ecologic data.*

Two recent legal rulings have implications concerning the recording of occupational illnesses and injuries and the identification of work-related Lyme disease. In one ruling, the Occupational Safety and Health Review Commission found the Occupational Safety and Health Administration (OSHA) correctly cited Caterpillar, Inc. for failing to record 167 occupational injuries and illnesses on its OSHA 200 form during 1986.<sup>1</sup> Although OSHA initially termed the failures to record as "egregious willful," the Commission stated that it was not willful, because Caterpillar acted in good faith and with the reasonable belief that its conduct conformed to the requirements of the law. The decision also suggested that the person responsible for recordkeeping be trained in completing the OSHA 200 form. In the other case, concerning workers' compensation, a U.S. district court judge in New York ruled for four Long Island Railroad (LIRR) workers who contracted Lyme disease after reportedly being bitten by ticks on the job, although the LIRR maintained that there was no proof that the workers were bitten on

the job. The judge found the LIRR, which had issued protective clothing and insect repellent to the workers, liable for medical expenses, lost wages, and the economic burden of pain and suffering (over \$500,000).<sup>2</sup>

A patient with Lyme disease recently was evaluated. The classification of the patient's condition for OSHA recordability was complicated because OSHA oral instructions (to consider Lyme disease as an injury) contradicted written advice (that Lyme disease is an illness). The following case report details the analysis of the OSHA recording instructions and discusses possible alternative strategies.

## CASE REPORT

A male worker reported to his company medical clinic with an engorged deer tick attached to his chest. He had been working outdoors on company grounds in a Lyme disease endemic area. The patient had no other symptoms or signs and the tick was removed promptly. Three weeks later, he returned to the clinic complaining of fatigue, a headache, and upper extremity joint pain; physical examination was normal. An enzyme-linked immunosorbent

assay (ELISA) test was done and reported as an optical density of 3.84 for *Borrelia burgdorferi*. Five weeks after the initial visit, the patient returned to the clinic. He was afebrile and had a warm erythematous circular rash 5 cm in diameter surrounding a small furuncle in the left groin. He was started on clarithromycin, 500 mg every 12 hours for 30 days. Followup Western blot testing revealed a detectable IgG response to *B. burgdorferi*. The rash resolved and the patient had no further sequelae.

**Case recording.** Clinically, the patient was diagnosed as having a tick bite, the furuncle, and Lyme disease, based on the characteristic rash and the serologic titer. The patient was officially recorded on the OSHA 200 form as having an occupational injury (the tick bite and Lyme disease, a complication), based on oral instructions from the OSHA Office of Recordkeeping. The case also was reportable to the New Jersey State Department of Health (DOH).

## DISCUSSION

The worker had classic Lyme disease, caused by *B. burgdorferi* transmitted by the deer tick, *Ixodes dammini*, according to the 1990 Council of State and Territorial Epidemiologists/Centers for Disease Control surveillance case definition.<sup>3</sup> This requires the presence of erythema migrans (equal to or greater than 5 cm diameter) or at least one objective



sign of musculoskeletal, neurologic, or cardiovascular disease and laboratory confirmation of infection. The case was unremarkable except for the issues concerning occupational recordkeeping.

The OSHA *Recordkeeping Guidelines for Occupational Injuries and Illnesses* provides information for determining which employers are subject to OSHA recordkeeping requirements, defining injuries and illnesses, determining their work relatedness, and recording injuries and illnesses on the OSHA 200 form.<sup>4</sup> The *Guidelines* do not have the force of law, however, because they were not promulgated in accordance with the Administrative Procedures Act. Nevertheless, they provide a fair and reasonable warning concerning the recording of injuries and illnesses according to OSHA.

According to the *Guidelines*, "Whether a case involves an injury or illness is determined by the nature of the original event or exposure which caused the case, not by the resulting condition of the affected employee. Injuries are caused by instantaneous events in the work environment. Cases resulting from anything other than instantaneous events are considered illnesses. This concept of illnesses includes acute illnesses, which result from exposures of relatively short duration."<sup>4</sup> Specifically, an occupational injury is "any injury such as a cut, fracture, sprain, amputation, etc., which results from a work accident or from an exposure involving a single incident in the work environment." An occupational illness is "any abnormal condition or disorder, other than one resulting from an occupational injury, caused by exposure to environmental factors associated with employment. It includes acute and chronic illnesses or diseases that may be caused by inhalation, absorption, ingestion, or direct contact." Furthermore, an injury or illness

is work related if it is caused, occurs, or surfaces either on the employer's premises or off the premises, with the employee engaged in work-related activity, in travel status or there as a condition of employment. An injury or illness is considered to be work related unless it is known to be caused wholly by nonoccupational factors, without any contribution from the work environment. Finally, every occupational death, every nonfatal occupational illness and any nonfatal occupational injury that involves loss of consciousness, restriction of work or motion, transfer to another job or medical treatment (other than first aid) must be recorded on the OSHA 200 form.

Lyme disease is not specifically mentioned in the *Guidelines*, but the OSHA Office of Recordkeeping has advised that work-related Lyme disease be considered an injury for recordkeeping purposes. This determination is based on the classification of any animal or insect bite or needlestick as an injury. An infection resulting from a laceration also is considered an injury, because of the nature of the original event (the laceration). This is consistent with recent instructions from the OSHA Office of Health Compliance Assistance concerning workers exposed to bloodborne pathogens (CPL 2-2.44C), which state that a worker who has a seroconversion for the pathogen should be recorded on the OSHA 200 form as having an injury, not an illness. However, this is inconsistent with the suggested recording of some other work-related infectious diseases. For example, in the *Guidelines* it is written, "For information purposes only," that hepatitis B among health care workers, which may be preceded by a needlestick, and rabies among animal handlers, which may be preceded by an animal bite or other injury to the skin, should be recorded as occupational illnesses. OSHA does state that some of its own

guidelines may appear inappropriate, because of the goal to make its system simple, equitable, and consistent with OSHA regulations.<sup>4</sup>

The current classification of Lyme disease is inconsistent with medical, epidemiologic, and ecologic data. Issues that complicate the recording of occupational Lyme disease on the OSHA 200 form include:

- Outdoor workers in areas of endemic disease are at an increased risk of infection and seropositivity.<sup>5-7</sup> Where there is no exposure, however, there is no risk.

- Certain outdoor leisure activities in endemic areas may increase the risk of infection and seropositivity.<sup>5,6</sup>

- In endemic areas, 30 to 50 percent of *I. dammini* nymphs and 40 to 70 percent of adults harbor and are capable of transmitting *B. burgdorferi*.<sup>5</sup>

- In endemic areas, the risk of infection after being exposed to an infected tick appears to be less than 5 percent.<sup>8,9</sup>

- Less than one-half of patients with Lyme disease recall tick exposure.<sup>5,10</sup>

- The *I. dammini* feeds on the host and may stay attached up to four days; it does not really bite instantaneously.<sup>5,6,11</sup>

- Less than one-half of infected persons do not have or detect erythema migrans.<sup>6,8</sup>

- There is considerable misdiagnosis of Lyme disease.<sup>12</sup>

- There is an increasing prevalence in endemic areas of persons who are seropositive due to past or asymptomatic infection with *B. burgdorferi*.<sup>12</sup>

- There are considerable problems with serologic testing for Lyme disease, which is not standardized, and false-positive results especially are common.<sup>13</sup>

Little has been written about the recording of work-related Lyme disease. In a review of occupational Lyme disease, Schwartz and Goldstein discuss certain legal aspects, with a focus



**Table. Example of a classification for Lyme disease-related findings.\***

Alternate classification	Exposed work in endemic area	History of tick bite or puncture wound at work	Confirmed clinical case
No injury or illness	No	No	No
Off-the-job illness	No	No	Yes
Occupational injury	No	Yes	No
Occupational injury and off-the-job illness	No	Yes	Yes
No injury or illness	Yes	No	No
Occupational illness	Yes	No	Yes
Occupational injury	Yes	Yes	No
Occupational injury and occupational illness	Yes	Yes	Yes

\*Note: OSHA currently requires that all work-related Lyme disease cases be classified as occupational injuries.

on workers' compensation.<sup>5</sup> Similarly, the recently issued guidebook from The Academy of Medicine of New Jersey, *The New Jersey Lyme Disease Syllabus* does not include a discussion of the occupational recording of Lyme disease.<sup>6</sup>

### CONCLUSION

Although there are clinical, ecologic, and epidemiologic uncertainties concerning Lyme disease, OSHA currently considers work-related Lyme disease as an injury. If medical and epidemiologic considerations are included in the decision-making process, an alternate classification framework to determine OSHA recordability might be appropriate (Table).

If the workplace or work activities are not in an endemic area, then all Lyme disease cases in the workplace would be considered non-work related and not recordable. All tick bites (or exposures) would be classified as injuries (even though the "bite" is not really instantaneous). For workers required to be outdoors in endemic areas and at least possibly exposed to *B. burgdorferi*, all cases of Lyme disease would be recordable as occupational illnesses, regardless of whether the worker remembers the occurrence of a tick bite or tick exposure. Inasmuch as there is an increased risk of Lyme disease in New Jersey for outdoor workers,<sup>5-7</sup> this strategy may result in false-positive recordings

for work relatedness and could entail additional costs for businesses. However, this is consistent with the recording of other conditions that are considered work related unless they are known to be caused wholly by nonoccupational factors, without any contribution from the work environment.<sup>4</sup> In addition, in areas not yet considered endemic for Lyme disease, false-negative cases could occur if the worker is the sentinel case. This is similar to the criteria for diagnosis for all cases of Lyme disease, i.e. that the patient has compatible clinical findings and a reasonable probability of exposure to ticks in an area where Lyme disease is endemic.<sup>10</sup> Thus, the framework is not a simple solution.

Alternatively, OSHA could simply resolve the current inconsistencies for Lyme disease and other conditions by eliminating the distinction between injuries and illnesses, which reportedly is being considered as part of a possible redesign of the recordkeeping system.<sup>14</sup>

Physicians should be aware of OSHA requirements and inconsistencies in order to provide high-quality determinations concerning work-related injuries and illnesses.

Physicians also should be aware of other statutory reporting requirements concerning occupational Lyme disease, in addition to those from OSHA. Nine states, but not New Jersey, require the reporting of any occupational dis-

ease, although occupational Lyme disease is not specifically mentioned.<sup>15</sup> In addition, Lyme disease is legally reportable as an infectious disease to the health departments in 49 states, including New Jersey, and the District of Columbia.<sup>16</sup>

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# An overview of the symptoms of multiple chemical sensitivities

Nancy Fiedler, PhD

*This paper describes a syndrome characterized by sensitivity to low-level chemical exposures or multiple chemical sensitivities (MCS). Patients suffering from MCS present numerous physical symptoms, reflective of multiple organ systems in the absence of detectable organic pathology.*

For any population of workers, there is a distribution of susceptibility to disease-causing agents.<sup>1</sup> Although the distribution probably is not bell-shaped for most pathogens, we can imagine such a curve, in which a small number of people are unusually sensitive, and become ill at low exposure levels or doses, while an equally small number of unusually resistant workers appear able to tolerate high exposures without ill effects. In recent years, it has become apparent that a substantial number of people report symptoms when exposed to extremely low levels of chemicals, orders of magnitude below levels that most people can tolerate.<sup>2</sup>

Multiple chemical sensitivities (MCS) or "environmental illness," is one of the more complex problems facing the occupational or environmental health professional. Such patients present numerous physical symptoms reflective of multiple organ systems in the absence of detectable organic pathology.<sup>3</sup> MCS patients attribute their symptoms to low-level chemical exposures. To manage symptoms, patients often resort to withdrawal from exposures. To accomplish this

withdrawal, patients may leave work and reduce participation in social activities and shopping in stores. Clearly, this results in significant disability and reduced quality of life. MCS also is a major concern for employers and insurance companies.

Investigators have drawn parallels between the clinical and demographic profile of MCS patients and other poorly understood syndromes such as chronic fatigue syndrome (CFS), fibromyalgia (FBS), irritable bowel syndrome (IBS), and somatization disorder.<sup>4</sup> These patient groups are comprised predominantly of women with a mean age in the fourth decade (ranges from ages 30 to 50 years). With the exception of somatization disorder, most of these patients have at least a moderate level of education.<sup>5,6</sup> In the absence of any physical or laboratory findings, the only method for separating MCS cases from these other disorders is through the use of clinical case criteria such as those suggested by Cullen (Table 1).<sup>7</sup> A similar definition was offered by the founding clinical ecologist, Theron Randolph, who included responses not only to volatile chemicals, but to more traditional

allergens such as inhaled molds, pollen, and dietary constituents such as food additives.<sup>8</sup>

It remains to be seen how well Cullen's criteria separate MCS from other disorders such as chronic fatigue or somatization. One of the aims at the Clinical Center of the Environmental and Occupational Health Sciences Institute (EOHSI) is to apply these criteria systematically and to assess the psychiatric, neuropsychological, immunologic, and olfactory function of MCS patients who do or do not meet these criteria.

## CASE CRITERIA

Patients who attribute their illness to low-level chemical exposures do not comprise a homogeneous group. Many patients do not meet all the criteria for MCS proposed by Cullen. For example, among the patients evaluated for MCS at the Clinical Center of EOHSI, 25 percent could not identify a single precipitating exposure after which they became ill. Their illness appeared to develop gradually over time rather than following any specific acute event, as suggested by Cullen.<sup>7</sup> While approximately 90 percent of patients report that multiple substances make them ill, there is no consistent group of substances reported across patients. Further, by definition, a broad array of symptoms are reported by patients. Table 2 provides a profile of the most common substances reported to



**Table 1. MCS clinical case criteria.<sup>7</sup>**

1. The disorder is acquired in relation to some documentable environmental exposure(s), insult(s), or illness(es).
2. Symptoms involve more than one organ system.
3. Symptoms recur and abate in response to predictable stimuli.
4. Symptoms are elicited by exposures to chemicals of diverse structural classes and toxicologic modes of action.
5. Symptoms are elicited by exposures that are demonstrable (albeit of low level).
6. Exposures that elicit symptoms must be very low, i.e. many standard deviations below "average" exposures known to cause adverse human responses.
7. No single widely available test of organ system function can explain symptoms.

**Table 2. Substances reported to produce symptoms in descending order.**

MCS (n = 23)	Percent Reporting
Perfumes/colognes	83
Spray paint	78
Perfumes in cosmetics	74
Cigarette smoke	74
Gasoline	70
Garage fumes	70
Diesel exhaust	70
Hair spray	70
Restroom deodorizer	61
Air fresheners	61

cause illness and Table 3 provides the most prevalent symptoms of MCS patients visiting the Clinical Center. Thus far, it appears that

there are at least two subgroups of MCS patients: those whose illness develops gradually and those whose illness follows an acute exposure event.

Other investigators have not applied the same case criteria as those outlined by Cullen but have studied patients who report sensitivities to chemicals and have sought treatment through a clinical ecologist or allergist.<sup>5,9</sup> These patient groups may be most representative of a subset of the patients who seek alternative care for chemical sensitivities. To date, no consensus exists regarding MCS case criteria. Therefore, it is difficult to compare research findings or clinical experiences among centers.

### MCS VERSUS ORGANIC SOLVENT SYNDROME

Solvent-exposed patients report some of the same symptoms, e.g. mood changes, concentration, memory deficits, as do patients with MCS. The differentiating factors are the symptom complex and the exposure background of these groups. For example, the central nervous system (CNS) is not the only organ system affected in MCS patients. In contrast, solvent syndromes are primarily CNS disorders. Type 1 solvent syndrome, known as the organic affective syndrome, involves transitory mood changes while types 2 and 3 include CNS symptoms of sustained mood changes and impaired intellectual function.<sup>10</sup> MCS patients most closely resemble acutely solvent-exposed patients whose symptoms theoretically dissipate when exposure has terminated. However, unlike solvent-exposed patients, MCS patients report that their symptoms recur when they are exposed to diverse groups of chemically unrelated substances in unusually low concentrations, e.g. pesticides, perfumes, solvent-based products. MCS patients do not report an exposure history consistent with that of patients who have permanent exposure-related

intellectual impairments such as types 2 and 3 (dementias) solvent syndromes. For example, solvent-exposed patients with permanent deficits report an average length of exposure between seven and ten years in occupational settings where solvents are handled on a daily basis as a part of a work process, e.g. painters.<sup>11</sup> The majority of MCS patients in the Clinical Center have never worked in an industry where chemical exposure occurs regularly.

### MCS AND OTHER SYNDROMES

From a superficial view, MCS can be differentiated from CFS, and IBS based on the purported causative factor, i.e. chemical exposures. MCS has been recognized more recently than these other vaguely defined illnesses, and has not yet reached the level of consensus criteria used to identify FBS, CFS, and IBS (Table 4).<sup>12</sup> One of the criteria for each of these disorders is that no underlying organic pathology can be found to account for the symptoms. All are diagnoses of exclusion without definitive diagnostic tests. While fatigue is reported among patients from each of these categories, fatigue is listed as the major criterion for CFS and a minor criterion for FBS. The criteria for FBS emphasizes chronic pain and detection of tender points upon palpation while CFS includes sore throat and axillary nodes in addition to myalgias. At least in some cases of CFS and FBS, a viral illness was the precursor. The criteria for IBS are focused on bowel symptoms and do not include fatigue or chronic pain. Unlike these other disorders, the criteria for MCS do not include a fixed set of symptoms. Patients we have evaluated do not present with the chronic pain of FBS, the viral symptoms of CFS, e.g. sore throat, nodes, or the bowel symptoms associated with IBS. As noted in Table 3, MCS symptoms

generally are more acute and directly connected with or at least attributed to exposures. To the extent that it is difficult to avoid all such exposures, MCS patients also exhibit some chronicity in their symptom presentation.

**PSYCHIATRIC STATUS AND PERSONALITY OF MCS PATIENTS**

The symptoms of MCS as well as the other syndromes defined previously are consistent with aspects of somatoform disorders. When one applies the standardized criteria of *DSM-III-R* that includes 13 or more unexplained somatic symptoms beginning before the age of 30 years, up to 20 percent of our patients qualify for this diagnosis.<sup>13</sup> With the revised criteria from *DSM-IV*, an even greater number of MCS patients may

meet criteria for somatization. In addition, compared to age- and sex-matched normal controls, MCS patients exhibited a significantly higher rate of depression, i.e. dysthymia, major depressive episode.<sup>13</sup> Other investigators also have observed a significantly higher rate of depression and total number of psychiatric diagnoses than chronic pain patients<sup>5</sup> and normal controls.<sup>9</sup> Depression also occurs at a significantly higher rate among CFS, IBS, and FBS patients.<sup>12</sup> However, 83 percent of MCS patients did not have an Axis I psychiatric disorder at the time of our evaluation. Thus, MCS is not completely comorbid with psychiatric disorders. Without premorbid data and longitudinal studies, it is difficult to determine whether underlying psychiatric disorders contribute to or result from MCS.

**ROLE OF CHEMICAL EXPOSURES**

While anecdotal reports indicated that MCS patients be-

**Table 3. Current (past 12 months) review of symptoms.**

MCS (n = 23)	Percent Reporting
Headaches	87
Shortness of breath	74
Muscle or joint pain	74
Dizziness	74
Back pain	70
Unusual weakness	61
Nausea or vomiting	57
Chest pain	52
Unusual fatigue	48
Abdominal pain	43

**Table 4. Criteria for diagnosis.**

Fibromyalgia*	Chronic Fatigue Syndrome <sup>21</sup>	Irritable Bowel Syndrome <sup>21</sup>
Obligatory Criteria:	Severe fatigue ≥6 mo.	—Abdominal pain relieved with defecation or associated with a change in frequency or consistency of stools
—Chronic, generalized aches, pains, or stiffness (involving ≥3 anatomic sites for ≥3 mo.)	Four or more symptoms present for ≥6 mo.:	—Disturbed defecation
—Absence of other systemic condition to account for these symptoms	—Impaired memory or concentration	—Bloating or a feeling of abdominal distension
—Multiple tender points at characteristic locations	—Sore throat	
	—Tender cervical or axillary lymph nodes	
	—Muscle pain	
	—Multi-joint pain	
	—New headaches	
	—Unrefreshing sleep	
	—Post-exertion malaise	

**Minor Criteria:**

- Disturbed sleep
- Generalized fatigue or tiredness
- Subjective swelling, numbness
- Pain in neck and shoulders
- Chronic headaches
- Irritable bowel syndrome

\*Modified from Yunus et al.<sup>18</sup> and Wolfe et al.<sup>19,20</sup>



came ill in response to a broad range of commonly encountered substances, few data were available to support this clinical observation. As a first step in the evaluation process, we routinely administer a substance questionnaire in which the patients check off those substances from a list of 122 items, e.g. perfumes, gasoline fumes, bug sprays, that make them ill. As expected, MCS subjects report significantly more substances that cause them to be symptomatic.<sup>14</sup> However, while MCS patients represent the extreme of the continuum, patients who met CDC criteria for CFS and asthmatics also reported significantly more substances that caused symptoms. We are studying whether these results simply represent a response bias in reporting substances and symptoms.

MCS appears to be, in part, mediated by odor perception. That is, MCS patients from the Clinical Center consistently report an increased awareness of odors and a sensitivity to odors that is greater than others. Doty evaluated the odor detection thresholds, nasal resistance, and symptoms of MCS patients relative to normal controls in response to rose oil (phenyl ethyl alcohol [PEA]) and methyl ethyl ketone.<sup>15</sup> While no significant differences in odor detection thresholds were noted between these groups, MCS subjects reported more symptoms and greater nasal resistance was documented. Using the sweet-smelling PEA and the irritating pyridine (PYR), we also found no significantly decreased odor detection thresholds for our MCS patients relative to normal controls. However, in response to suprathreshold levels of PEA, MCS patients reported significantly more symptoms of irritation compared to normal controls. PEA, administered at these levels, is not considered an irritant, while PYR is noxious and irritating. MCS and normal controls were similar in their ratings

of symptoms of irritation in response to PYR. These data confirm what MCS patients report clinically. That is, in response to relatively low concentrations of even normally pleasant substances, such as PEA, MCS subjects report symptoms of irritation.

## TREATMENT

As for other syndromes with no definitive organic pathology, treatment for MCS, at this point, involves primarily behavioral interventions.<sup>2</sup> While a significant portion of these patients report symptoms consistent with depression, they often are unable to tolerate any medications, reporting a high frequency of side effects to psychotropic medications. This is consistent with the tendency to be highly sensitive to or aware of bodily sensations. Thus, psychotropic medications that have been helpful for CFS, IBS, and FBS may not be useful for MCS patients. Clinical ecologists offer a variety of desensitization treatments that have not been independently validated.

Both clinicians and patients meet a great deal of frustration in attempting to alleviate the symptoms and disabilities of this syndrome. Approaching MCS as primarily a psychiatric problem often is not helpful. The process of symptom perception and interpretation is a complex interaction between the psyche and soma. While medicine often tries to separate these factors, in the context of healing patients, they cannot be separated. The most compelling data to support this state is the significant impact of psychosocial interventions on survival time following surgery for cancer.<sup>16</sup> The science of symptom perception has grown during the past decade. For example, Cioffi developed a model of symptom perception in which somatic sensations are interpreted based on internal schema formulated from individual and familial experiences with previous

illness. Thus, the perception and interpretation of symptoms is never a purely somatic phenomenon.<sup>17</sup>

Instead of assigning MCS to a psychiatric diagnostic category, it is important to understand the complex interaction between psychological factors and chemical exposures that produce symptoms. At EOHSI, there is a behavioral support group for MCS patients in which patients learn to identify patterns of symptom response and the precipitating factors that contribute to illness. Behavioral coping strategies that include prudent avoidance of exposure, cognitive restructuring to reduce the stress response, and relaxation training to promote physical and emotional well-being are taught. The key to interventions is that each patient gains insight into the illness and the strategies that work for that individual to reduce symptoms and promote wellness. In addition, many patients find help and practical suggestions for coping with this problem from the National Center for Environmental Health Strategies, a self-help organization. ■

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# Occupational disease surveillance at DOH

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*The DOH provides reported patients, their physicians, and their employers with educational materials and consultations to prevent additional exposure to occupational hazards. Recognition and reporting of occupational diseases are essential for prevention.*

There are three components to the New Jersey State Department of Health's (DOH) occupational disease surveillance system: case identification from reporting sources, which includes physicians, hospitals, and clinical laboratories; data collection and analysis at DOH; and intervention activities directed at reported individuals, coworkers, and work-sites from which cases are reported. Surveillance data currently are collected on several occupational disorders, including occupational lead toxicity, occupational asthma, silicosis, asbestosis, and other heavy metals toxicity. This paper describes the data on these conditions (Table) and the actions that have resulted from case reports.

## OCCUPATIONAL LEAD TOXICITY

Lead is a persistent hazard in workplaces throughout the United States.<sup>1</sup> Surveillance data from 20 states, including New Jersey, for 1993 showed 24,025 reports of elevated blood lead levels in occupationally exposed adults.<sup>2</sup> DOH estimates that there may be as many as 100,000 lead-exposed workers in New Jersey.<sup>3</sup>

Since 1985, clinical laboratories in New Jersey have been required to report lead toxicity in adults to DOH, and physicians have been required to report the same since 1990. Lead toxicity in adults is defined as a blood level of 25  $\mu\text{g}/\text{dl}$  or greater. (New Jersey recently lowered the reporting level in children to 20  $\mu\text{g}/\text{dl}$ .) Almost all of the adults reported with lead toxicity have been tested because of occupational exposure to lead. This testing is required by the federal Occupational Safety and Health Administration (OSHA) for workers who are exposed to lead in air above 30  $\mu\text{g}/\text{m}^3$ .

Individuals with blood lead levels equal to or greater than 40  $\mu\text{g}/\text{dl}$  are interviewed by DOH and sent educational materials. The interviewer obtains information on conditions at work that may have caused or contributed to the worker's elevated blood lead level. The individual being interviewed also provides DOH with information on medical care provided by the employer for lead-exposed workers. The physicians who ordered these patients' blood lead tests also are contacted to ensure that they are providing medical followup in compliance

with OSHA's requirements for medical monitoring of lead-exposed workers.

The worker's employer receives an educational mailing and is interviewed by telephone concerning measures in place to control exposure to lead. The employer may be referred by DOH to OSHA for enforcement of the OSHA lead health standard if other workers appear to be at risk of lead exposure, or DOH may conduct its own on-site consultative evaluation of the lead exposure hazard.

Over 20,700 reports of lead toxicity from 4,263 individuals have been received since the beginning of mandatory reporting (1985) through 1993. One percent of the reports were received from physicians. One thousand six hundred of the reported individuals' peak blood lead levels (38 percent) were equal to or greater than 40  $\mu\text{g}/\text{dl}$ . Approximately 500 reported individuals have had at least one blood level greater than or equal to 60  $\mu\text{g}/\text{dl}$ ; OSHA requires that employers remove from exposure individuals with one blood lead level this high or with three consecutive blood lead results greater than or equal to 50  $\mu\text{g}/\text{dl}$  without loss of pay or benefits until their blood lead level goes below 40  $\mu\text{g}/\text{dl}$ .

Medical attention also is imperative and required. Interviews by DOH with 45 physicians who had ordered blood lead tests for 62 individuals reported with blood lead levels greater than or

equal to 50 µg/dl indicated that medical followup on many of these workers may not have been adequate to prevent continued lead poisoning of these workers and their coworkers.

Many construction workers, including those involved with residential lead abatement and lead paint removal on steel structures, such as bridges and water towers, were reported to DOH with particularly high blood lead levels. Construction workers represent only 7 percent of all reported individuals, but represent 21 percent of all individuals reported with a blood lead level greater than or equal to 40 µg/dl and 36 percent of individuals with a blood lead level greater than or equal to 70 µg/dl.

Three hundred fifty-nine workplaces were identified by name as the sources of lead exposure for individuals reported with a blood lead level greater than or equal to 25 µg/dl. Companies in primary metals manufacturing, chemical manufacturing, and construction trades predominated as the sources of lead exposure in reported individuals. Almost all of the 223 companies that had at least one employee reported with a blood lead level greater than or equal to 40 µg/dl were interviewed by DOH and received educational materials. Thirty-nine workplaces were evaluated on-site by DOH industrial hygienists and 29 workplaces were referred to OSHA for enforcement of health standards.

Several actions have been taken to address the special hazards of lead in construction. First, DOH has worked with the New Jersey State Department of Transportation (DOT) to ensure that all bridge construction companies under contract with DOT maintain complete compliance with OSHA standards.<sup>4</sup> Second, DOH industrial hygienists conducted a pilot study of lead hazards at five lead abatement jobs and found wide variation in employer and employee knowl-

edge of the hazards of lead and safe lead abatement strategies. To help address this problem, DOH is providing technical assistance to contractors and other programs and agencies involved with residential and commercial lead abatement. Certification and training of lead abatement workers are mandated by state law.

## OCCUPATIONAL ASTHMA

Voluntary physician reporting of patients with occupational asthma began in 1988; in 1990, physician reporting of occupational asthma became mandatory (*N.J.A.C. 8:57-3.2*). Individuals hospitalized with acute respiratory conditions due to fumes and vapors are reported by hospitals to the occupational asthma surveillance system under *N.J.A.C. 8:57-3.1*.

Reported patients are interviewed to determine the nature of the exposure, the name and address of the employer, associated medical information (smoking history, medications, and symptom history), and the number of coworkers at risk. With the patient's permission, employers are sent educational materials and offered on-site technical consultations to identify and control exposure hazards.

Three hundred fourteen reports of patients with occupational asthma were received from 1988 through 1993. Eighty percent of these cases were first reported by physicians, and 20 percent of the cases were reported from hospitals. One hundred eighty-five cases (59 percent) met the epidemiologic case definition and an additional 26 cases (8 percent) met reporting guidelines but did not provide confirmatory evidence of workrelated disease. The most frequently reported asthma inducers among confirmed cases were isocyanates (10 percent), aldehydes (including formaldehyde and glutaraldehyde) (9 percent), diesel exhaust (5 percent), pesticides (5 percent), and oil mist (4 percent).

## SILICOSIS

Silicosis is a public health concern in New Jersey because of the many silica-using industries in the state, including foundries, ceramics manufacturing, glass manufacturing, and sand mining. It has been estimated that as many as 25,000 New Jersey workers may be exposed to silica,<sup>5</sup> putting them at risk of developing silicosis into the next century.

Under the SENSOR Program, NIOSH is funding seven state health departments to conduct surveillance for silicosis. Hospital discharge data are the primary source of case reports in New Jersey. All patients with ICD 502 as a discharge diagnosis must be reported by hospitals (*N.J.A.C. 8:57-3.1*). To a lesser extent, mandatory physician reports (*N.J.A.C. 8:57-3.2*), death certificate data, and company medical screening data also identify cases. Work histories are obtained from reported patients, and, where possible, x-rays and medical records are reviewed by an occupational physician.

Of the 906 reported cases, 325 cases (36 percent) have been confirmed by the physician using an epidemiologic case definition published by NIOSH that includes a history of work with silica and positive radiologic or pathologic findings of silicosis.<sup>6</sup> Seventy-eight confirmed cases (24 percent) were exposed to silica dust in ceramics manufacturing, 47 cases (15 percent) were exposed to silica dust in foundries, 40 cases (12 percent) were exposed to silica dust in mining in the state, and the rest of the cases were exposed in a wide variety of work settings from construction and cosmetics manufacturing to jewelry making.

Sixty-one companies that were identified by name from work histories of silicosis patients were found to use silica now. They were evaluated on-site by DOH industrial hygienists. Respiratory protection programs, air monitor-



Table. *DOH occupational disease surveillance system.*

Condition	Number of New Cases Reported						Total
	From beginning of reporting through 1988	1989	1990	1991	1992	1993	
Elevated blood lead levels <sup>1</sup>	2,154	539	542	320	287	421	4,263
Asbestosis <sup>2</sup>	1,124	474	519	799	774	726	4,416
Occupational asthma <sup>3</sup>	29	40	60	53	43	89	314
Silicosis <sup>4</sup>	509	49	144	66	68	70	906
Elevated blood and urine mercury levels <sup>1</sup>	200	17	87	61	24	17	406
Elevated blood and urine cadmium levels <sup>1</sup>	46	37	144	17	2	15	261
Elevated blood and urine arsenic levels <sup>1</sup>	60	17	20	5	1	24	127

<sup>1</sup>Data sources: Laboratory and physician reports. Reporting began in 1985.

<sup>2</sup>Data sources: Physician and hospital reports. Reporting began in 1985.

<sup>3</sup>Data sources: Physician and hospital reports. Reporting began in 1988.

<sup>4</sup>Data sources: Hospital reports, physician reports, death certificates, and employer medical screenings. Reporting began in 1979.

ing, engineering controls, and housekeeping were inadequate or not present in most of these companies. More than one-half of DOH's recommendations for improvement in these areas were followed at least partially by employers.<sup>7,8</sup>

## ASBESTOSIS

Physician and hospital reporting of asbestosis are mandatory. DOH has been receiving reports of patients with asbestosis from hospitals since 1985 and from physicians since 1990. Eighteen percent of the 4,416 reported patients have been reported by physicians. Many of the physician reports are of workers who were exposed to asbestos already in place, e.g. maintenance of pipes and boilers, whereas patients reported by hospitals were more likely to have been exposed while working in asbestos products manufacturing. (Most of the asbestos products plants in New Jersey are closed.) Educational materials on the medical and legal aspects of asbestos-related diseases are available. Local health departments are required under

N.J.A.C. 8:52-3.5 to evaluate the potential for current exposure of workplaces of hospitalized asbestosis patients. Local health departments have conducted more than 560 followup evaluations since 1989.

## CADMIUM TOXICITY

Cadmium exposure exists in many industrial settings including the use of cadmium pigments in plastics, cadmium plating, and silver soldering. Cadmium exposure can produce health effects ranging from acute pulmonary edema to chronic kidney disease, and possibly lung and other cancers.<sup>9</sup> Beginning in 1992, OSHA required employers to take steps to lower worker exposures to cadmium and conduct medical surveillance of exposed workers, including biological monitoring of cadmium levels in blood and urine. DOH estimates there may be as many as 20,000 cadmium-exposed workers in New Jersey. The use of cadmium is decreasing due to occupational and environmental regulations.

Cadmium toxicity became reportable by New Jersey physi-

cians in November 1993; it has been reportable by clinical laboratories and hospitals since 1985. Reportable levels are currently 5 µg/L of whole blood and 3 µg/g of creatinine in urine. In eight and one-half years, 324 reports of elevated cadmium levels, 205 in blood (mean 7.86 µg/L) and 119 in urine (mean 19.3 µg/L), have been received on 261 individuals.

DOH's followup of elevated cadmium reports follows the model for occupational lead toxicity. Reported individuals receive a self-administered survey by mail, the physician receives a packet of educational materials, and the exposure control practices in the workplace are evaluated by telephone interview with the employer. The employer is alerted by mail to any deficiencies compared to what is required by the OSHA cadmium standard (29 CFR 1910.1027 for general industry; 29 CFR 1926.1027 for construction). Various databases also are used to identify workplaces that may use cadmium. Employers are contacted to verify use of cadmium and are provided

with materials on the requirements of the OSHA standard. It is anticipated that more employers will begin to conduct biological monitoring of currently and previously exposed cadmium workers, as required by OSHA.

## ARSENIC AND MERCURY TOXICITY

The major uses of arsenic are in insecticides, weed killers, and wood preservatives. Arsenic also is present in heavy metal alloys. Skin contact can cause irritation, burning, itching, thickening, and color changes. High or repeated exposure can damage the nerves causing weakness and numbness of the arms and legs; arsenic also can cause stomach problems and liver damage. Arsenic is a carcinogen and a teratogen.<sup>10</sup> OSHA has regulated worker exposure to inorganic arsenic since 1978 (29 CFR 1910.1018). Medical surveillance is required by OSHA but biological monitoring is not required.

Exposure to mercury and its compounds occurs during the calibration of laboratory glassware; during the manufacture of thermometers and other instruments; during the manufacture of electrical switches and fluorescent light bulbs; and during dental amalgam manufacture and use; and in the manufacture of batteries and chemicals. Tremor, erethism, and dental problems characterize chronic mercury exposure. Acute poisoning symptoms begin with cough, chest tightness, difficulty breathing, and upset stomach. Later, lung edema may occur.<sup>11</sup>

Arsenic and mercury toxicity became reportable by New Jersey physicians in November 1993; they have been reportable by laboratories and hospitals since 1985. Reportable levels for arsenic are 0.07 µg/ml in blood and 100 µg/L in urine; for mercury, reportable levels are 2.8 µg/dl in blood and 20 µg/L in urine.

Since 1985, 140 reports of

elevated arsenic levels—35 reports in blood (mean 0.2 µg/ml) and 105 reports in urine (mean 251.6 µg/L)—have been received on 127 individuals. In that same eight and one-half year period, 690 reports of elevated mercury levels, 253 cases in blood (mean 8.85 µg/dl) and 437 cases in urine (mean 78.6 µg/L), have been received on 406 individuals. It is estimated that 50 percent of arsenic reports and 90 percent of mercury reports represent occupational exposure.

Both mercury and arsenic reports are followed up by mailing educational materials to the ordering physician and offering assistance if the doctor believes the elevated level represents significant occupational exposure.

Because many clinical laboratories are not proficient in analyzing for cadmium, arsenic, and mercury, it is important for physicians ordering blood and urine tests for these metals to check with the laboratory performing the analysis to be certain it has demonstrated at least 70 percent proficiency over a one-year period in the Quebec Interlaboratory Comparison Program for the analysis being ordered.

Possible interference in these analyses due to mercury ingested with fish can be avoided by ordering the urine rather than blood test. With arsenic, urine is the test of choice but fish ingestion must be eliminated for two to three days prior to testing. Alternatively, speciation of urine arsenic samples may be ordered to differentiate between occupational exposure and fish ingestion.

## DISCUSSION

DOH has well-established surveillance programs for several major occupational disorders: occupational lead toxicity; occupational asthma; silicosis; asbestosis; and cadmium, arsenic, and mercury toxicity. For these conditions alone, DOH has received almost 25,000 reports on more than

10,000 individuals since these surveillance systems began in the 1980s, yet it is certain that reporting is incomplete.<sup>12,13</sup> DOH provides centralized data collection, analysis, and data dissemination, and oversees or provides interventions designed to eliminate exposures to causative agents. DOH also provides assistance to physicians in diagnosing and treating these conditions by assisting in the identification of exposure sources and by providing technical consultations.

A comprehensive occupational disease surveillance system ultimately relies on accurate diagnosis followed by timely reporting by physicians. The work-relatedness of some diseases often is missed because these diseases are frequently indistinguishable clinically from diseases caused by other factors. A detailed occupational history for each patient is the cornerstone for physician recognition of the work-relatedness of diseases in medical practice.<sup>14</sup> Recognition must be followed by reporting in order for public health surveillance to be comprehensive and effective.

Physicians are assured that DOH maintains occupational disease reports in strictest confidence. Physicians are encouraged to make use of DOH's multitude of educational materials including hazardous substance fact sheets giving toxicologic profiles of over 1,000 chemicals, its directory of occupational medicine services,<sup>15</sup> and technical consultation services by industrial hygienists and other public health professionals. ■

The authors are affiliated with DOH. The paper was submitted in January and accepted in June 1995. Address reprint requests to Ms. Stanbury, DOH, CN 360, Trenton, NJ 08625-0360.

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# **MEDICAL SOCIETY OF NEW JERSEY 1996 ANNUAL MEETING**

*April 30 through May 4, 1996  
Trump Taj Mahal Casino/Resort  
Atlantic City, NJ*

## **DAILY SCHEDULE**

### **WEDNESDAY, MAY 1, 1996**

- 8:00 A.M. Registration Opens
- 8:30 A.M. Message Center Opens
- 9:00 A.M. AMA Delegation Meeting
- 10:00 A.M. Educational Program
- 11:30 A.M. The Academy of Medicine of New Jersey Lecture
- 12:30 P.M. Exhibits and AMA-ERF Boutique Open
- 1:30 P.M. House of Delegates
- 3:00 P.M. Reference Committees
- 7:00 P.M. Officers' Reception/Dinner

### **THURSDAY, MAY 2, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. Reference Committees
- 9:30 A.M. Exhibits Open
- 12 NOON Golden Merit Award Ceremony/Reception
- 12 NOON Luncheon/Meeting "Women in Medicine"
- 1:30 P.M. House of Delegates (Election)
- 4:00 P.M. JEMPAC Political Forum
- 5:00 P.M. JEMPAC Wine and Cheese Reception
- 6:00 P.M. Camden County Medical Society Reception Honoring President and Mrs. Louis L. Keeler

### **FRIDAY, MAY 3, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. House of Delegates
- 9:30 A.M. Exhibits Open
- 12:30 P.M. Luncheon Meeting—Members of the Hospital Medical Staff Section
- 1:00 P.M. Exhibits Close
- 7:00 P.M. Inaugural Reception
- 8:00 P.M. Inaugural Dinner Honoring Anthony P. Caggiano, Jr, MD

### **SATURDAY, MAY 4, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. HIV Educational Program



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### FEBRUARY 1996

FEBRUARY 7th

#### Salt Retention and Diuretic Resistance in Congestive Heart Failure

*Wadi Suki, M.D.*

Professor of Medicine and Molecular Physiology and Biophysics

Baylor College of Medicine, Chief, Renal Section, Methodist Hospital, Houston, TX

FEBRUARY 14th

#### Aspirin and Warfarin Therapy

*Alexander Graham Turpie, M.B., F.R.C.P.*

Professor of Medicine

McMaster University, Hamilton General Hospital, Hamilton, Ontario, Canada

#### Abnormalities of Thrombosis in Cardiovascular Disease

*Barry S. Collier, M.D.*

Murray M. Rosenberg Professor of Medicine  
Mount Sinai School of Medicine,  
Chair, Department of Medicine, Mount Sinai  
Hospital, New York, NY

FEBRUARY 21st

#### Advances in Magnetic Resonance Imaging for the Internist

*Robert MacMillan, M.D.*

Associate Professor of Radiology

Medical College of Pennsylvania and  
Hahnemann University

Director, Cardiac MRI, Division of Cardiovascular  
Diseases, Hahnemann University Hospital

*Paula Touloupoulos, M.D.*

Assistant Professor of Radiology

Medical College of Pennsylvania and Hahnemann  
University, Department of Radiology, Hahnemann  
University Hospital

### FEBRUARY 1996

FEBRUARY 28th

#### Pathogenesis and Treatment of Reflux Esophagitis

*Roy C. Orlando, M.D.*

Professor of Medicine and Physiology

Tulane University School of Medicine

Chief, Section of Gastroenterology and Hepatoma,  
Tulane University Medical Center,  
New Orleans, LA

### MARCH 1996

MARCH 6th

#### Clinical Pathologic Conference

*Dina Capalongo, D.O.*

*Michael Downing, M.D.*

*Lawrence McDermott, M.D.*

*Lisa Scheib, M.D.*

Chief Residents, Hahnemann University Hospital

MARCH 13th

#### New Concepts in Pulmonary Medicine: Sleep Apnea, Respiratory Failure

*Barry Fuchs, M.D.*

Assistant Professor of Medicine

Medical College of Pennsylvania and Hahnemann  
University, Division of Pulmonary and Critical Care  
Medicine, Hahnemann University Hospital

*Joanne Getsy, M.D.*

Assistant Professor of Medicine

Medical College of Pennsylvania and Hahnemann  
University, Director, Sleep Lab., Division of  
Pulmonary and Critical Care Medicine, Medical  
College of Pennsylvania Hospital

### MARCH 1996

*Edward S. Schulman, M.D.*

Professor of Medicine

Medical College of Pennsylvania and Hahnemann  
University, Division of Pulmonary and Critical Care  
Medicine, Hahnemann University Hospital

MARCH 20th

#### Cutaneous Signs of Systemic Disease

*Melda Isaac, M.D.*

Assistant Professor of Dermatology

Medical College of Pennsylvania and Hahnemann  
University

MARCH 27th

#### Medical Education and Medical Practice—What's Next: A View from Washington and the AMA

*Richard F. Corlin, M.D.*

Speaker of the House of Delegates

American Medical Association, Assistant Clinical  
Professor of Medicine, UCLA School of Medicine,  
Los Angeles, CA

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

JANUARY 10, 1996

Diabetes

Course Directors: Leslie I. Rose, M.D.,  
Allan B. Schwartz, M.D.

Lecturers: Alan J. Garber, M.D., Ph.D.  
and Harry Gottlieb, M.D.

JANUARY 17, 1996

Addiction Medicine

8:30-12:00 noon

Course Director: Vincent Zarro, M.D., Ph.D.

Lecturer: David E. Smith, M.D.

FEBRUARY 14, 1996

Abnormalities of Thrombosis

Course Director: Marc Cohen, M.D.

Lecturers: Alexander Graham Turpie, M.B.  
and Barry S. Collier, M.D.

MARCH

No Seminar

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

**Full Disclosure Statement:** All faculty participating in continuing medical education programs sponsored by The Medical College of Pennsylvania and Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

**Statement of Accreditation:** The Medical College of Pennsylvania and Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The Medical College of Pennsylvania and Hahnemann University designates 1.0 credit hour of Category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities.

This program is eligible for 1.0 credit hour for each hour of attendance in Category 2A of the American Osteopathic Association.



# DOCTORS' NOTEBOOK

## TRUSTEES MINUTES

A meeting of the Medical Society of New Jersey (MSNJ) Board of Trustees was held on November 19, 1995, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

**President's report.** Was presented with a report on the proposed HMO regulations by Fred M. Palace, MD; the regulations were drafted by the New Jersey State Department of Health (DOH). Urged physicians to read the draft copy and send questions or comments to MSNJ. Also noted that MSNJ is represented on the HMO Advisory Committee by Drs. Fred M. Palace and Patricia Klein; Dr. Keeler and Mr. Weisfeld serve as alternates.

**Specialty reports.** Received reports from UMDNJ; Gary S. Carter, president, New Jersey Hospital Association; Mrs. Jane Lorber, fellowette, Medical Alliance to MSNJ; and Ravi Goel, MSNJ Student Association.

**Executive director's report.** Presented recommendations developed by the American Medical Association (AMA) that will redefine how the organizations of the Federation collaborate and contribute to national policy on behalf of physicians and patients. Also, in the report was a proposal to modify the representation from state societies based on a ratio of 1 delegate per 1,000 AMA members who are members of the state medical society.

**Council on Communications.** Noted the following items: MSNJ public relations efforts will

promote MSNJ's viewpoint on the stopping of the utilization of the Milliman and Robertson guidelines, thereby supporting MSNJ's legislative and regulatory efforts to prevent excessive reliance by HMOs on guidelines that jeopardize quality of care; *NEW JERSEY MEDICINE*'s new format includes scientific and clinical articles; and an article on economic credentialing will be prepared for *NEW JERSEY MEDICINE*.

### Council on Legislation.

**1. Legislation.** Approved the positions recommended by the Council on Legislation on the health care reform, insurance, tort reform, and public health and related issues current state legislation for action lists. Also, approved the positions recommended by the Council on Legislation on the referred legislation list. And, approved a position of no position on the health care reform, tort reform,

and public health and related issues current bills of interest lists.

**2. Medicare legislation.** Approved a recommendation to forward a communication to the New Jersey congressional delegation in support of physicians' right to privately contract with patients.

**Committee on Medical Education.** Approved the recommendation that the New Jersey delegation defer action on submitting a resolution to the AMA requesting that funds earmarked for graduate medical education be channeled directly to teaching hospitals pending the review of forthcoming federal legislation. Also, noted that a full four-year term of approval was awarded to MSNJ by the Committee for Review and Recognition of the Accreditation Council for Continuing Medical Education.

**Committee on International Medical Graduates (IMGs).**

## ARE YOU MOVING?

Please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

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City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Adopted the following resolution, "Resolved, that MSNJ support a position of nondiscrimination in the education and licensure of medical graduates and ask that the state seek uniform licensure requirements for all medical graduates."

**Audit Review Committee.** Approved the following recommendations: that the audited financial statements be accepted and that a copy be forwarded to each com-

ponent society; that Amper, Politziner & Mattia be continued as the external auditors; and that the guidelines developed by the management and approved by the Audit Review Committee to govern MSNJ's investments be adopted.

**Strategic Planning Task Force.** Accepted the report of the Strategic Planning Task Force, noting that the current compo-

sition of the Board of Trustees should remain the same.

**MedAc.** Heard from Harry Carnes, MD, and Mr. Martin on the elections, noting that 90 percent of the candidates supported by MedAc were elected.

**AMA activities.** Heard from Palma E. Formica, MD, AMA trustee, on the House Medicare reform bill. □

## UMDNJ NOTES

**Researchers test vaccine for psoriasis.** A new vaccine that may relieve—and even cure—the chronic skin ailment psoriasis is being tested at the University of Medicine and Dentistry of New Jersey (UMDNJ). The condition, which afflicts five million Americans, is caused by a disorder of the immune system that allows T cells to cluster on the skin and form a scaly plaque. The vaccine, which appears to have minimal side effects, deactivates the T cells, returning skin to its normal condition.

The eight-month study is being conducted at UMDNJ-Robert Wood Johnson Medical School in New Brunswick, one of six sites of a national trial funded by the Immune Response Corporation of Carlsbad, California, developer of the vaccine, called IR 502. Principal investigator on the study is Dr. Alice B. Gottlieb, chief of the Division of Dermatology at UMDNJ-Robert Wood Johnson Medical School.

**Study finds air bags and seat belts reduce serious facial injuries.** Motorists who use seat belts and drive cars equipped with air bags reduce the risk of serious facial injuries by 75 percent from car accidents, according to a four-year study by researchers at UMDNJ-Robert Wood Johnson Medical School. The findings were based on a

study by plastic surgeons at the medical school of 2,300 New Jersey-based accidents.

Dr. Borah co-authored the study with Dr. Jeffrey S. Hammond, associate professor of surgery and section chief, trauma/surgical critical care, and Dr. Philip W. Wey, assistant professor of surgery.

**New findings on rectal and colon cancer.** One in five colorectal cancer patients who undergo a colostomy could be treated with more conservative surgery combined with radiation and chemotherapy rather than removal of the rectum. This observation is a result of a study by Dr. T.S. Ravikumar, chief of surgical oncology at The Cancer Institute of New Jersey of 1,778 colorectal patients who underwent this invasive surgery between 1980 and 1993.

Dr. Ravikumar, a professor of surgery at UMDNJ-Robert Wood Johnson Medical School, presented his research, the largest and most comprehensive of its kind in the nation, at a national meeting of the American College of Surgeons.

**Peer outreach program targets teens at risk for HIV.** Teenagers with first-hand experience with high-risk behavior that increases the risk of HIV infection are counseling youth at risk of contracting the deadly virus.

The adolescent educators are participating in a new community-based program called POWER (Peer Outreach Workers Educating Risk Takers), which is directed by the Division of Adolescent and Young Adult Medicine at UMDNJ-New Jersey Medical School.

Dr. Robert Johnson, director of the division, said experience with other programs in the division taught him that the message must be taken to the streets or at least 50 percent of those teens who are in jeopardy because of their lifestyles will not be reached. The program includes teens who previously had high-risk behavior because they deliver the message most effectively.

**Dedication of Health Education Center.** State Senate President Donald T. DiFrancesco (R-Union) was honored by UMDNJ and Union County College (UCC) at a dedication ceremony for the Regional Health Education Center in Scotch Plains.

The Center offers programs in the allied health professions sponsored jointly by the UMDNJ-School of Health Related Professions and UCC. Edward T. Kelley II, assistant dean for off-campus programs at the UMDNJ-School of Health Related Professions, is the Center's director. □ Stanley S. Bergen, Jr, MD, president



The Board of Trustees of The Academy of Medicine of New Jersey (AMNJ) has named the 1996 recipients of the awards that will be presented at the Annual Awards Dinner on May 29, 1996, at the Chanticleer in Short Hills.

Donald K. Brief, MD, of South Orange will receive the Edward J. Ill Award presented "to that physician of New Jersey who merits recognition by AMNJ for distinguished service as a leader in the medical profession and in the community at large."

Dr. Brief is director of surgery at Newark Beth Israel Medical Center. He is one of the outstanding surgeons in New Jersey. He is a past-president of the Vascular Society of New Jersey, the Oncology Society of New Jersey, the New Jersey Chapter, American College of Surgeons, and the New Jersey Division of the American Cancer Society. He has served as president of the medical staff of Newark Beth Israel Medical Center and currently is serving on the AMNJ Board of Trustees.

He has been active with many nonprofit and charitable organizations including the State of Israel Bonds where he received the Maimonides Award. He also is a recipient of the UMDNJ-New Jersey Medical School Chief Residents Award for outstanding contributions to surgical training.

AMNJ's Citizen's Award is presented "to that citizen or group of citizens of New Jersey who merit recognition by AMNJ for distinguished service in the interest of the health and welfare of the community at large." The 1996 Citizen's Award has been granted to Lorraine Sciara of Pine Brook.

Ms. Sciara has devoted her professional career to the care of the terminally ill and to the provision of resources for the care and support of patients and families in circumstances demanding sustained personal commitment. She is an active member of numerous professional organizations and her organization was the recipient of the Outstand-

ing Volunteer Group Award from the Volunteer Center of Greater Essex County and the Outstanding Volunteer Group Award for Health Care by the Governor's Office on Volunteerism, both in 1994. In 1992, she was honored as Executive Director of the Year by the Center for Non-Profit Corporations in New Jersey.

In keeping with AMNJ's efforts to offer additional educational services and benefits to its Fellows, AMNJ, with the assistance of the New Jersey Institute of Technology, is in the process of reviewing current computer and communications capabilities. AMNJ will be seeking ways to provide new and innovative programs. Part of this review is a questionnaire AMNJ is sending to members regarding their needs and expectations now and in the future. If you would like to participate in this process, please contact Sondra Moylan, Director of Research and Education. □ Alan J. Lippman, MD, president

## PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in further information concerning these physicians, please direct inquiries to them.

### Anesthesiology

**Geoffrey W.T. Ndeti, MD**, 36 Franklin Ave., Rosemont, PA 19010. Nairobi (Kenya) 1976. Group or partnership. Available.

### Gastroenterology

**Simhjadri Kompella Sastry, MD**, 15A Lakeview Ave., Leonia, NJ 07605. Andhra Medical College 1976. Board certified (IM). Board eligible (GI). Solo or partnership. Available.

**Rawel Singh, MD**, 8569 Everett Ave., St. Louis, MO 63117. GND

University (India) 1980. Board certified. Single or multispecialty group. Available.

### Internal Medicine

**Howard M. Abrams, MD**, 1175 York Avenue, Apt. 3K, New York, NY 10021. UMDNJ 1984. Board certified (IM and GI). Group with partnership. Available soon.

**T.S. Krishnaswamy, MD**, P.O. Box 98765, Tacoma, WA 98498. Jipmer Medical School (India) 1962. Board eligible. Group, partnership, solo. Available.

**Ashwin N. Trivedi, MD**, 71 Webster St., Floral Park, NY 11001. Baroda Medical College 1980. Board eligible. Group or solo. Available.

### Nephrology

**Suk Hyeon Yun, MD**, 504 Summit Ave., Fort Lee, NJ 07024. New York Medical College 1989. Board

certified (IM). Board eligible (NEPHR). Group or partnership. Available.

### Psychiatry

**Dorothy Brozek, MD, MSN**, 200 E. Wynnewood Rd., D-1, Wynnewood, PA 19096. Albany Medical College 1990. Group or partnership. Board eligible. Available.

### Surgery

**Eric Gross, MD**, 26 Chestnut Ridge Lane, Amberst, NY 14228. Mt. Sinai School of Medicine (New York) 1988. Board eligible. Group or partnership. Available.

### Urology

**Richard P. Campo, MD**, 1130 McIntyre, Ann Arbor, MI 48105. Mt. Sinai School of Medicine 1989. Available.

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**FEBRUARY 7, 1996**

**3:30-5:30 PM**

### **Hypertension: Old and New Drugs for Whom and Why?**

**Moderator: J. David Ogilby, M.D.**

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**MARCH 6, 1996**

**3:30-5:30 PM**

### **Gender Differences in Heart Disease**

**Moderator: Mariell Jessup, M.D.**

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All faculty participating in continuing medical education programs sponsored by Presbyterian Medical Center are expected to disclose to the program audience any real or apparent conflict(s) of interest related to the content of their presentation(s).



# CONTINUING EDUCATION

## MEDICINE

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (in *italics*) for further information.

### January

- 10 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 10 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 10 **New Treatments in Cerebrovascular Disease**  
St. Mary's Hospital, Passaic (AMNJ)
- 10 **Prostatic Carcinoma**  
The General Hospital Center at Passaic, Passaic (AMNJ)
- 16 **Meeting of the NJ State Society of Anesthesiologists**  
Somerset Marriott Hotel, Somerset (AMNJ)
- 17 **Family Medicine Series**  
UMDNJ-Robert Wood Johnson Medical School, Camden (Cooper Hospital)
- 17 **Congestive Heart Failure**  
St. Mary's Hospital, Passaic (AMNJ)
- 17 **Thriving in a Competitive Environment: Strategies for Success**  
MSNJ Executive Office, Lawrenceville (AMNJ)
- 17 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 17 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 18 **Abdominal Tumors in Children**  
Saint Barnabas Medical Center, Livingston (AMNJ)
- 24 **Hepatitis**  
St. Mary's Hospital, Passaic (AMNJ)
- 24 **Multiple Antibiotic Resistant Bacteria**  
The General Hospital Center at Passaic, Passaic (AMNJ)

- 24 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 24 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 25 **NJ Institute of Ultrasound in Medicine Meeting**  
JFK Conference Center, Edison (AMNJ)
- 31 **Identification and Management of Perinatal HIV Infection**  
Union Hospital, Union (AMNJ)
- 31 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 31 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)

### February

- 1 **Neuropsychiatric and Psychosocial Aspects of HIV/AIDS**  
Carrier Foundation, Belle Mead (AMNJ)
- 3 **Bipolar Disorders: The State of the Field**  
UMDNJ-Robert Wood Johnson Medical School, New Brunswick (UMDNJ)
- 7 **Adrenal Diseases**  
St. Mary's Hospital, Passaic (AMNJ)
- 7 **Electrolyte Imbalance**  
The General Hospital Center at Passaic, Passaic (AMNJ)
- 7 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 7 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 8 **Scientific Meeting: Head and Neck Oncology Section**  
The Manor, West Orange (AMNJ)

- 14 **Multiple Myeloma**  
St. Mary's Hospital, Passaic (AMNJ)
- 14 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 14 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 15 **Diagnostic Radiology Section Meeting**  
Saint Barnabas Medical Center, Livingston (AMNJ)
- 21 **Family Medicine Series**  
UMDNJ-Robert Wood Johnson Medical School, Camden (Cooper Hospital)
- 21 **Cataracts: Diagnosis and Indications for Surgery**  
St. Mary's Hospital, Passaic (AMNJ)
- 21 **Collagen Disease Update**  
The General Hospital Center at Passaic, Passaic (AMNJ)
- 21 **Thriving in a Competitive Environment: Strategies for Success**  
MSNJ Executive Office, Lawrenceville (AMNJ)
- 21 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 21 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 22 **Visiting Professor Lecture**  
Saint Barnabas Medical Center, Livingston (AMNJ)
- 28 **Interhospital Endocrine Rounds**  
University Hospital, Newark (AMNJ)
- 28 **Medical Grand Rounds**  
VA Medical Center, East Orange (AMNJ)
- 29 **Infection Control in the HIV Era**  
Union Hospital, Union (AMNJ)

**NEXT MSNJ BOARD MEETING  
JANUARY 21, 1996**

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## Bayshore Community Hospital Holmdel, NJ

### Continuing Medical Education Lecture Series 12 noon-1 pm

Date: January 19, 1996

Topic: Will be announced

Speaker: Will be announced

Date: January 26, 1996

Topic: "Onychomycosis: Diagnosis and  
Treatment Options"

Speaker: Will be announced

Date: February 2, 1996

Topic: "Allergic Rhinitis: Clinical  
manifestation and treatment"

Speaker: Michael Viksman, MD

Date: February 9, 1996

Topic: "Chronic Pain and Substance Abuse"

Speaker: Robert L. Gabel, MD

Date: February 16, 1996

Topic: "Urinary Incontinence"

Speaker: B. Surya, MD

Date: February 23, 1996

Topic: "Update on Asthma Management"

Speaker: Donald Perlman, MD

Date: March 1, 1996

Topic: "Lipids"

Speaker: To be announced

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# IN MEMORIAM

## DAVID W. BEGGS

David Walker Beggs, MD, died on May 31, 1995, at the age of 66. Dr. Beggs was born on April 21, 1929, in East Orange. He was graduated from Jefferson Medical College, Pennsylvania, in 1955 and received a New Jersey medical license the following year. Dr. Beggs completed an internship at Muhlenberg Hospital, Plainfield. During his medical ca-

reer, Dr. Beggs was a dermatologist with an office in Red Bank and was a staff physician for American Cyanamid Company, Bound Brook. He was attending at Riverview Medical Center, Red Bank. Dr. Beggs was a member of our Monmouth County and Somerset County components. Dr. Beggs served in the United States Navy in the late 1950s.

## LOUIS V. BELOTT

Born on September 17, 1914, in West Orange, Louis Vincent Belott, MD, passed away on March 4, 1995, at the age of 80. He was graduated from Cornell University Medical School, New York, in 1941. Dr. Belott maintained a private family practice in Orange for over 50 years and was on the staff of the Hospital Center of Orange and St. Mary's Hos-

pital, Orange. He was a member of the Essex County Heart Association, of our Essex County component, and of the American Medical Association. He also was past-president of the Clinical Society of the Oranges and Montclair. Dr. Belott served in the United States Navy during the Korean conflict.

## REUBEN BLOCK

We regret to announce the death of Reuben Block, MD, at the age of 74. Dr. Block maintained a private practice in Camden from 1952 until 1985. Dr. Block was born on January 9, 1920, in Philadelphia, Pennsylvania. After receiving a medical degree from Hahnemann Medical College, Philadelphia, in 1946, Dr. Block served in the United States Army until 1949. He completed an internship at Mount Sinai Hospital, Philadelphia, and a residency at Cooper Hospital, Camden. During his medical career as a urologist, Dr. Block was

chief of urology from 1969 to 1975 at Our Lady of Lourdes Medical Center, Camden; was affiliated with Kennedy Memorial Hospital, Stratford, and Underwood-Memorial Hospital, Woodbury; and was on the teaching staff at Hahnemann Medical College. Dr. Block was a member of our Camden County component, of the Medical History Society of New Jersey, and of the American Medical Association; a fellow of the American College of Surgeons; and a diplomate of the American Board of Urology.

## JOSEPH D. BRENNA

Lifelong Trenton resident Joseph Dondiego Brenna, MD, passed away on February 23, 1995, at the age of 74. Dr. Brenna was born on March 27, 1920, in Trenton. Dr. Brenna was gradu-

ated from Duke University School of Medicine, North Carolina, in 1944. Dr. Brenna completed an internship at Orange Memorial Hospital, West Orange, and a residency at St. Francis



Medical Center, Trenton, and at Western Pennsylvania Hospital, Pittsburgh. He was a general practitioner in Trenton and was director of surgery at St. Francis Medical Center; president of the medical staff at St. Francis Medical Center; surgical consultant to the New Jersey State Department of Corrections; and medical director for Aetna Health Plans, New Brunswick. In ad-

dition to being a member of our Mercer County component, he was a member of the American Medical Association, a fellow of the American College of Surgeons, a diplomate of the American Board of Surgery, and on the teaching faculty at Hahnemann Medical College, Pennsylvania. Dr. Brenna was a captain in the United States Air Force.

#### **ROBERT T. DUNN**

Word has been received of the death of Robert Thomas Dunn, MD, on October 25, 1994. Dr. Dunn was born on November 16, 1921, in Paterson. He was awarded a medical degree from New York Medical College in 1949. He completed an internship and a residency at St. Vincent's Hospital, New York, and received a New Jersey medical license in

1952. Dr. Dunn was a cardiologist with offices in Packanack Lake. He was affiliated with Chilton Memorial Hospital, Pompton Plains, and Paterson General Hospital. Dr. Dunn was a member of our Passaic County component and of the American Medical Association. Dr. Dunn was a captain in the United States Air Force from 1951 to 1953.

#### **PAUL H. FLUCK**

Born on August 27, 1910, in Philadelphia, ophthalmologist Paul Havens Fluck, MD, passed away on March 10, 1995, at the age of 84. Dr. Fluck maintained a medical office in Lambertville from 1936 until he retired in 1968. Dr. Fluck was graduated from Hahnemann University School of Medicine, Philadelphia, in 1935. He completed an internship at William McKinley

Hospital, Trenton, in 1936. During his medical career, Dr. Fluck was a medical research consultant for the Army Biological Center, Maryland, and was a member of our Hunterdon County component and of the American Medical Association. He served in the United States Army from 1949 to 1953. Dr. Fluck resided in Lambertville.

#### **JAMES R. MERKEL**

James Richard Merkel, MD, of Tewksbury Township, passed away on March 12, 1995. Dr. Merkel was a medical director at Bell Communication Research, Piscataway, for 18 years. Dr. Merkel was born on January 9, 1923, in Dayton, Ohio, and was awarded a medical degree in 1950 from the University of Cincinnati College of Medicine, Ohio. Dr. Merkel completed an internship and a residency at Christ Hospital, Cincinnati. He maintained a private practice in Cincinnati in the mid 1950s. Dr. Merkel was on the teaching faculty of Northwestern University

Medical School, Chicago; was affiliated with Morristown Memorial Hospital; and was a member of our Morris County component, of the American Medical Association, of the Medical Society of the State of New York, of the Medical Society of the County of New York, and of the American Diabetes Association. Dr. Merkel also was a diplomate of the American Board of Occupational Medicine and a fellow of the American College of Preventive Medicine. Dr. Merkel served in the United States Army Air Corps during World War II.

# CLASSIFIED

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Effective April 1996 Issue—See Pages 62 and 63



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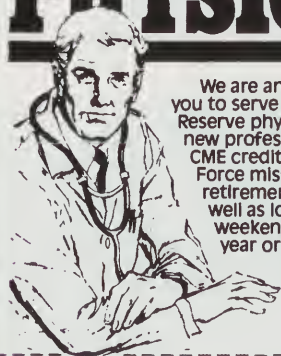
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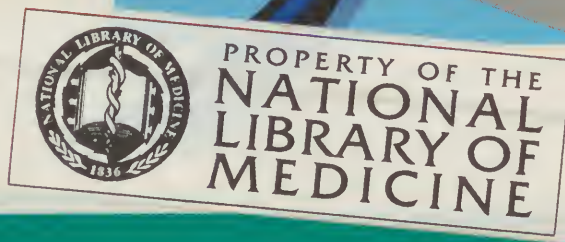
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# Newswatch

## **PHYSICIANS MUST NOTIFY PIP CARRIERS . . .**

Under new law physicians are required to inform automobile insurers when caring for patients covered under Personal Injury Protection (PIP) insurance policies. The physician's notice must be submitted within 21 days of treatment. A bill to the carrier will satisfy this provision.

This requirement represents a compromise that incorporates changes sought by the Medical Society of New Jersey (MSNJ) and agreed to by Governor Christie Whitman.

## **HMO REGULATIONS DISPUTED . . .**

Detailed, uniform comments on Health Commissioner Len Fishman's proposal to stiffen regulation of health maintenance organizations (HMOs) were submitted by all so-called "provider" representatives on the Commissioner's HMO Advisory Committee. The comments were drafted by MSNJ.

Emerging as a key point of controversy was Mr. Fishman's proposal to establish an independent appeal mechanism for utilization review decisions. HMO representatives strongly opposed the idea, especially if providers as well as consumers could file appeals. But, the idea also has legislative support, led by State Senate Health Committee Chair Jack Sinagra of Edison.

MSNJ Past-President Fred M. Palace, MD, served as the providers' spokesperson when the providers and HMOs submitted comments on January 19. For a copy of a 3-page executive summary of the provider comments, or the full 27-page comment document, called "Putting Patients First," contact Karen Monsees at MSNJ, telephone 609/896-1766, extension 245.

## **RBRVS UPDATES FINALIZED . . .**

Surgery carries a 3.8 percent increase, and primary care a 2.3 percent decrease, in conversion factors for Medicare reimbursement for 1996. For other procedures, there is a 0.4 percent increase.



The changes reflect a 2.0 percent rise in the Medicare Economic Index. Also incorporated are 1996 Volume Performance Standards, which were set at 9.3 percent for primary care and negative 2.3 percent for surgery.

The new conversion factors themselves are \$40.80 for surgery, \$35.42 for primary care, and \$34.63 for other, rounded to cents. In adopting these changes, the federal government accepted 90 percent of the suggestions made by the RVS Update Committee, consisting of representatives of the American Medical Association (AMA) and specialty societies.

## **RADIOACTIVE WASTE FACILITY NEEDED . . .**

Radiologists, oncologists, and other physicians presumably have an interest in the proposed development of a low-level radioactive waste facility in New Jersey. Transporting nuclear waste out of state is becoming far less viable. For additional information, contact the Disposal Facility Siting Board at telephone 609/777-4247.

## **POLICY ADVANCES DISCUSSED . . .**

Several health policy developments of potential interest to physicians were noted in the first 1996 issue of *Medicine & Health*, a venerable Washington-based newsletter. First, the newsletter noted that the Medicare Work Group of the American Academy of Actuaries has criticized both Democrats and Republicans for relying too heavily on provider pay cuts to reduce overall spending.

The actuaries found no evidence that such cuts actually lead to spending declines. They expressed concern that cuts could adversely affect access and quality of care.

Second, the newsletter cited a Weiss Ratings study that showed HMOs paying their chief executive officers higher compensation than any other industry. Overall, the study found that the health insurance industry pays CEOs 80 percent above average.

The newsletter further reported on a recommendation of the Pew Health Professions Commission report, which called for multi-professional evaluation of physicians. Top physician groups have objected to the idea.

"People of the Year" awards were given by *Medicine & Health* to House Speaker Newt Gingrich (who else?) and Senator Nancy Landon Kassebaum. The Republican from the Empire State of the South was said by the newsletter to have earned top honors because he "set the agenda for 1995" and took the AMA "by storm."

In conferring runner-up honors on Mrs. Kassebaum, the newsletter called her the "retiring icon of incrementalism." The Sunflower State Republican leaves the Senate next year.

Finally, *Medicine & Health* also observed that premium prices for "Medigap" coverage are rising 30 percent on average. In New Jersey, the Medigap market is being shaken by the entry of a new Blue Cross HMO product for seniors.

## **TOBACCO CONTROL MEASURE PASSES . . .**

Although the New Jersey Legislature has so far failed to pass a raise in the tobacco tax, the state's solons have adopted a measure to toughen enforcement on the ban of cigarette sales to minors. Under S-1186, passed in the waning days of the old Legislature largely with MSNJ support, local health departments will be responsible for enforcement efforts.

The governor also signed S-263/A-1163, which increases the penalty for anyone who sells or gives tobacco to a minor to \$250 for the first offense, \$500 for the second offense, and \$1,000 for the third and subsequent offenses.

The Division of Taxation, which licenses the sellers of tobacco products, is authorized by the new law to suspend a retailer's tobacco license for the first offense and revoke the license for the second and subsequent offenses following a municipal hearing.

"With more than 3,000 American teenagers starting to smoke every day, we must do all that we can to make cigarettes less available to children," said Governor Whitman. "We must not only educate teenagers about the dangers of smoking, we also must limit their access to tobacco."

## **KEELER ADVOCATES NEW BUDGET PRIORITIES . . .**

MSNJ President Louis L. Keeler, MD, publicly called on Health Commissioner Fishman to place greater budgetary priority on tobacco control, enforcement of managed care regulations, family violence prevention, comprehensive school health education, and electronic data interchange.

Dr. Keeler spoke at the New Jersey State Department of Health budget hearings on January 3.



### **HOME CARE SLOT GOES TO STATE PHYSICIAN . . .**

George T. Hare, MD, of the Camden County Medical Society, has been named by the AMA to the Advisory Committee for Home Care Program. The committee functions under the Joint Commission on Accreditation of Healthcare Organizations.

### **INTERNATIONAL TOUR PLANNED . . .**

Commissioner Fishman is seeking physician participation in a planned fall 1996 foreign tour to be conducted under the American People Ambassador program. For additional information contact Marge Bolling at MSNJ, telephone 609/896-1766, extension 248.

### **STUDENT SESSION RESCHEDULED FOR MARCH 9 . . .**

The AMA-Medical Student Section Chapter at UMDNJ-Robert Wood Johnson Medical School has rescheduled the section VII conference for March 9, 1996. The theme of the conference asks the question, "M.D.?" Speakers will include Joseph Gonnella, MD, from Jefferson Medical College, and Palma E. Formica, MD, a member of the AMA Board of Trustees. The conference will be held at the Robert Wood Johnson Medical School in Piscataway. For information, contact John Lee, Student Affairs Office, UMDNJ, 675 Hoes Lane, Piscataway, NJ 08854.

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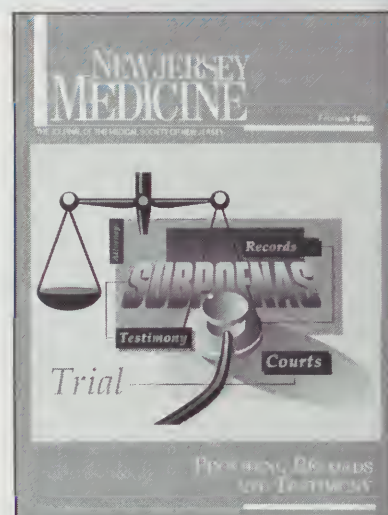


# NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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## On the Cover

Attorney Steven I. Kern explains the rights and obligations of physicians to provide records and testimony. The story begins on page 85. Cover: Williams and Philips.

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# MSNJ NEWSLETTER

## THE PRO IN THE PUBLIC EYE

Transitioning effectively from a mainly regulatory to a mostly supportive quality management resource, The Peer Review Organization of New Jersey (The PRO) has launched a series of initiatives designed to help hospitals and health professionals improve care throughout the state.

In the Cooperative Cardiovascular Project, The PRO is comparing the performance of specific hospitals to national and state norms across ten quality indicators for care of patients who have suffered an acute myocardial infarction or heart attack.

The ten cardiovascular indicators are: reperfusion (thrombolytics or primary angioplasty); timing of thrombolysis; timing of primary angioplasty; beta blocker at discharge; aspirin during hospitalization; timing of aspirin; aspirin at discharge; use of ACE

inhibitors for patients with poor left ventricular function; avoidance of calcium channel blockers for the same group of patients; and smoking cessation counseling.

What is unclear, though, is the extent to which hospital-specific findings eventually may find their way into the news media or other routes of public dissemination.

Other projects (with much less threat of public reporting of adverse findings) include blood conservation, discharge planning, breast cancer screening, influenza prevention, postoperative pain management, decubitus ulcers, and others.

The PRO also has been chosen by the State Department of Human Services to provide quality assurance for the Medicaid managed care program.

## PATIENT PROTECTION ACT EFFORTS

Members of the state Senate and Assembly are responding to postcards from constituents who were reached through a direct mail campaign conducted by MSNJ. The campaign drew attention to the Patient Protection Act, proposed legislation to protect consumers and health care providers under managed care.

In one example, Assemblywoman Loretta Weinberg wrote to MSNJ to say: "My office has heard from hundreds of constituents, who are concerned

about the ever-increasing role insurance company employees have in determining appropriate health care. While the march to managed care seems both inevitable and financially efficient, I have heard heartbreaking examples of patients whose cases have come up against bottom line considerations that adversely affected their health. Obviously something must be done." The Teaneck Democrat is a member of the Health and Human Services Committee and a cosponsor of the bill.

## ORGAN TRANSPLANTATION

Joel Kallich, PhD, has been named by the New Jersey State Department of Health to conduct a study of organ transplantation services. The research will include interviews with key health

professionals. For information contact Susan Spock at 609/292-9354.

Public information materials for patients have been developed by the U.S. Department of Health and Human Services to promote HIV testing of pregnant women. Last year the celebrated ACTG-076 study found a two-thirds drop in cases of transmission of HIV in utero as a result of zidovudine therapy.

New Jersey law now requires physicians to offer HIV testing to pregnant patients. Compliance is expected to prevent hundreds of pediatric AIDS cases annually. For information contact the HIV/AIDS Treatment Information Service at 800/448-0440.

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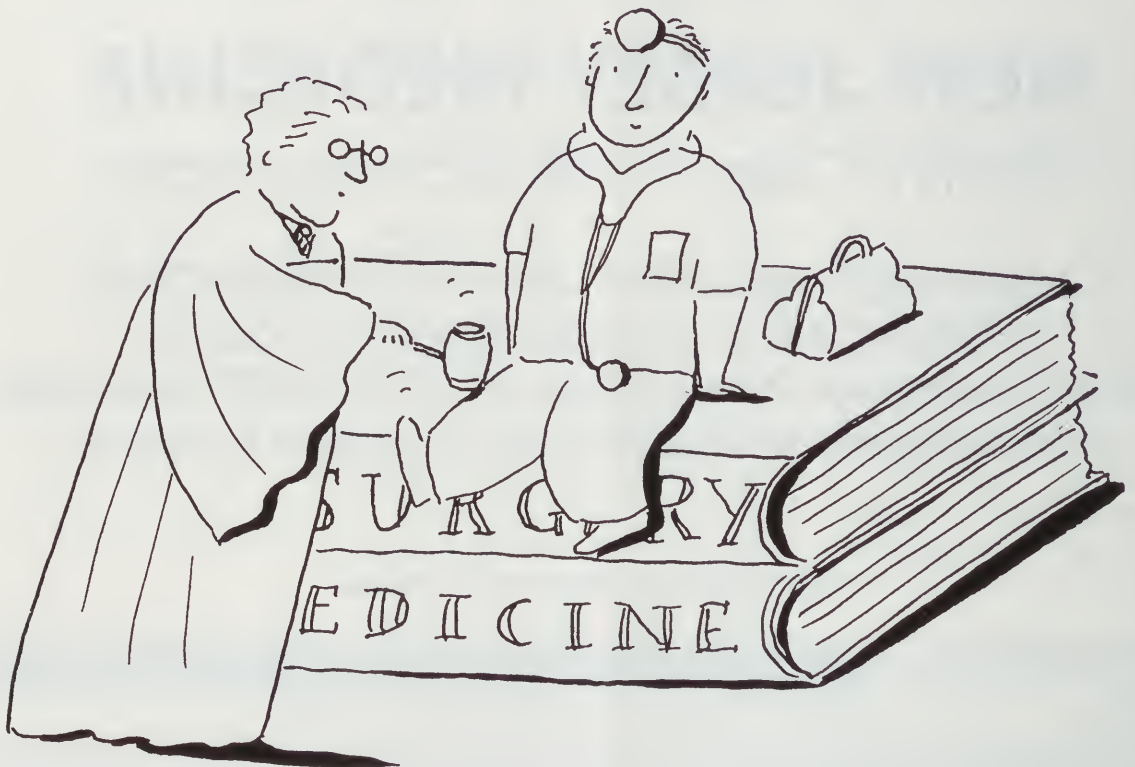
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# PROFESSIONAL LIABILITY

## MALPRACTICE POLICY DEVELOPMENTS

**Good year in malpractice.** Malpractice underwriting spun from a \$366 million loss in 1993 to an \$87 million gain in 1994, according to a Best's report summarized in *Medical Liability Monitor*. The giddy improvement reflected both a 9 percent increase in premiums and a 9 percent drop in incurred losses. Premiums for 1994 stood at \$4.8 billion.

Best's further observed an increase in nationwide market share by the Medical Inter-Insurance Exchange from 2.0 in 1992 to 2.2 in 1994.

**Malpractice cost total?** The federal government's General Accounting Office (GAO) has found itself unable to comply with a House of Representatives request to estimate the total costs of the medical liability system.

The request was made by Ways and Means Committee Chair Bill Archer of Texas to bolster the House Republicans' case for including tort reform measures in Medicare legislation. Earlier, privately conducted research attributed only 1 percent of total health care expenditures to the liability system.

In a brief report, the GAO asserted that the 1 percent figure included "only a portion" of all costs. Defensive medicine, risk management, claims resolution, and liability of manufacturers of drugs and devices would drive up the total, said the watchdog agency—but it could not propose a feasible methodology for determining the additional costs.

**Tort cost breakdown.** According to a new Tillinghast study, less than one-half of the malpractice premium dollar goes to plaintiffs in awards and settlements. As summarized by *Medical Liability Monitor*, plaintiffs gain 24 percent of the total in economic compensation and 22 percent in payments for pain and suffering.

The remainder, concluded Tillinghast, goes for administration (24 percent), plaintiffs' legal costs (16 percent), and defense legal costs (14 percent).

**Malpractice and managed care.** Besides reporting diverse study results, *Medical Liability Monitor* also has been seeking to disclose emerging trends. The newsletter cautions that managed care probably will spur liability claims.

"As it begins to dawn on the public that financial incentives and per capita payments to physicians in managed care plans could translate into denials of needed care," says the newsletter, "any bad results could trigger malpractice actions."

Claims will allege treatment delays, excessive utilization review, and inadequate case management, according to experts.

The periodical went on to quote a US Healthcare attorney as commenting, "Plaintiff lawyers don't know how to do managed care organization claims. But they will catch up."

In defense, managed care firms intend to characterize all malpractice claims as benefits issues—that is, as disputes between

enrollees who say that their policies should have paid for more medical care, and HMOs and other third-party payers who argue that people who purchase economical coverage forgo many desired services.

Contractual and other legal relationships between physicians and managed care entities also will come into play, reports the newsletter. And, it adds, physicians' premium rates will depend increasingly on the number of covered lives instead of just specialty.

**Radiology claims breakdown.** Missed diagnoses, failures to order tests, and procedure complications all account for substantial increases in malpractice claims against radiologists, according to research reported in the *American Journal of Radiology* and summarized in *Medical Liability Monitor*.

Leonard Berlin, MD, and Jonathan W. Berlin, MD, found a "striking" rise in breast cancer diagnosis claims. The Illinois father-son investigative team also found dramatic increases in claims involving alleged failures to order angiography, magnetic resonance imaging, and computed tomography. The study period embraced 20 years, ending in 1994.

Worse, the researchers anticipate additional climbs in claims against radiologists as a result of trends related to the rise of managed care.

## MALPRACTICE TIPS

**Keeping sufficient notes.** Physician-patient communication is important in preventing and defending against malpractice

claims. As *Loss Minimizer* recently discussed, sufficient documentation also is an important deterrent—and good medicine as well.

"Unclear written notes are the catalysts for plaintiffs' verdicts and settlements," proclaimed the California-based newsletter.



Several cases in which documentation made the difference in the legal result were presented.

*Loss Minimizer* noted, "Many doctors complain that the threat of malpractice litigation imposes excessively high standards for documentation." But, clear and

sufficient notes also are needed in peer review and other important quality control activities, the newsletter argued.

Moreover, coordination of care within a team of health professionals can only be accomplished if generalist and specialist physi-

cians, nurses, associated health professionals, and others consistently produce and read accurate, informative notes, observed the physician-friendly periodical.

## MALPRACTICE VERDICTS

**Automobile accident.** At four o'clock one afternoon, a 51-year-old grandmother, on disability leave from her job as a sewing machine operator, was an unrestrained front seat passenger in an automobile crash occurring at high speeds. The woman sustained a severe impact to the chest but remained conscious and moaning.

EMTs arrived promptly on the scene and summoned the state police helicopter, which also responded with dispatch. A paramedic telephoned a local community hospital and was connected to a nurse. The nurse relayed the paramedic's conversation to the base command physician in an adjoining room.

Although the paramedic raised the possibility of transporting the victim by helicopter to a trauma center, the base command physician understood that vital signs were normal and ordered a transfer to another local hospital by ambulance.

At the receiving hospital an emergency physician saw the patient first, summoned a general surgeon, and diagnosed a cardiac contusion. An x-ray was of indifferent quality but later appeared to disclose a widened media stinum.

After completing office hours, the surgeon arrived at the emergency department two and one-half hours after being called. Quickly, the surgeon diagnosed a lacerated aorta. The hospital was not equipped for the necessary surgery. The surgeon called the trauma center to attempt to arrange a transfer, which occurred following an additional delay.

Surgery was initiated by a trauma surgeon within seven hours of the collision. The surgery was unsuccessful. An autopsy supplied no evidence of a significant cardiac condition.

The patient was survived by her widower, a career military officer, and by six adult children. She was further survived by two grandchildren in her custody.

Litigation was brought in New Jersey against the base command physician for failing to order transfer to the trauma center, against the nurse on the telephone for failing to facilitate the transfer, against the emergency physician for failing to diagnose the lacerated aorta, against the general surgeon for delay in responding and for failing to execute the transfer to the trauma facility, and against the trauma surgeon at the trauma center for failing to consent immediately to the transfer.

At trial, an expert cardiothoracic surgeon testified for the plaintiff that the outer layer of the aorta had remained intact for several hours, delaying hemorrhaging, while the two inner layers had lacerated. The expert offered the opinion—based partly on his Vietnam War experience, which convinced him of the benefits of speedy transfer to a trauma facility—that an operation properly performed within four hours of the injury would have yielded an 80 percent chance of success.

Along with an expert emergency physician also testifying for the plaintiff, the cardiothoracic surgeon declared that a lacerated aorta should be ruled out in any

case of severe chest injury. These experts also interpreted the x-ray as evidencing the laceration. The latter view was disputed by a defense expert, who found the film too poor in quality to be useful.

The defense disagreed with the plaintiff's rosy view of the probability of success of early surgery. An expert emergency physician testified for the defense that the odds of survival were virtually nil from the start.

An audiotape of the telephone conversation at issue was relied on by the plaintiff and nurse as supporting the contention that the base command physician was overruling the paramedic's recommendation for removal to the trauma center by helicopter. The base command physician allowed as how the usual course was not to "second-guess" recommendations from the field but insisted that he was unaware that the helicopter was on the scene.

The plaintiff contended that the patient's moaning reflected severe pain and that the absence of hemorrhaging demonstrated the advantages of early surgical intervention. The base command physician's defense emphasized the normal vital signs and seemingly routine nature of the injuries as reported to the base command physician secondhand.

Communication also was an issue in the case against the general surgeon, who maintained that he was not adequately informed by the emergency physician. The surgeon further testified that he called the trauma center twice. By his account, the first call elicited the response that no beds were available, and the second



call 40 minutes later led to the delayed approval. However, the trauma surgeon countered that only one call was made and that consent was immediately given. This defendant observed that trauma centers are not at liberty to refuse transfers and that, in any case, beds indeed were available.

The case against the general surgeon was settled during trial. At the close of evidence the plaintiff agreed to a dismissal of the case against the trauma surgeon.

An expert emergency physician testified for the defense that the defendant emergency physician's response was reasonable in light of the poor quality of the x-ray. This defendant stated that he summoned the general surgeon immediately but had no notes to support this recollection.

The general surgeon's notes did support the surgeon's view that an emergency was not described, but the notes were prepared after the event and so were discounted by the plaintiff.

According to commentators, the decedent's husband was not a facile communicator on the witness stand in describing the extent of the loss suffered by the family. A vocational expert testified for the plaintiff, however, that the value of the lost earnings and lost household services was approximately \$270,000.

The jury found that death was 69 percent attributable to negligence, apportioned as follows: 36 percent to the settling general surgeon; 32 percent to the base command physician; and 1 percent to the emergency physician. The remaining 31 percent causation was attributed to the underlying trauma. The nurse was found not negligent. Damages were assessed at \$407,824 for wrongful death and \$350,000 for the patient's pain and suffering following the accident.

**Traction in delivery.** Toward the end of an otherwise generally unremarkable pregnancy, an ultrasound test suggested an estimated fetal weight of 10.5

pounds. Three days later the patient delivered. Encountering shoulder dystocia, the obstetrician used traction.

Following delivery there was no evidence of bruising on the neck, but a brachial plexus tear appeared. Erb's palsy in the left shoulder and upper arm eventually was manifest.

A malpractice action was brought against the obstetrician in New Jersey, based on the claim that following the ultrasound test the physician should have arranged for specially trained personnel to be present at delivery. The plaintiff further claimed that the child's injuries were due to excessive traction on the neck.

An expert obstetrician testified for the plaintiff that the defendant should have taken precautions, because the high fetal weight increased the risk of shoulder dystocia from 1 in 150 to 1 in 4. The expert stated that a brachial plexus injury generally will not occur in the absence of excessive traction. Only an emergency, added the expert, would justify traction on the neck.

Also appearing on the plaintiff's behalf, an expert pediatric neurologist performed a physical examination on videotape to demonstrate that the child, age 5 at trial, could not raise her arm above her shoulder. The tape revealed a left arm that was shorter and thinner than the right arm.

The plaintiff presented to the jury the prospect of a child who would be taunted by peers, shunned by potential dating partners, unable to perform many daily tasks during an expected 70-year life span, and incapable of lifting her children over her head.

The defendant denied using excessive traction and stressed the lack of bruising. He could not, however, satisfactorily explain the tear or provide documentary evidence of attempted maneuvers or of an emergency. He lost the verdict of the jury, which awarded \$1.5 million.

**Diabetes in pregnancy.** A pregnant woman was receiving prenatal care from a third-year resident who had skipped the second year due to outstanding work. Gestational diabetes was identified, and borderline macrosomia was detected on ultrasound two months before the patient went into labor.

A certified nurse-midwife commenced delivery. When the midwife encountered shoulder dystocia, she summoned the resident. The two professionals intermittently attempted the delivery, using traction.

Apgar scores of zero at one minute and zero at five minutes were recorded, but subsequently the baby thrived. A brachial plexus injury resulted from the delivery, however, and a diagnosis of Erb's palsy was established.

A malpractice case was brought against both professionals in New Jersey on the theory that an obstetrician-gynecologist should have been asked beforehand to provide backup, given the signs of high risk.

The defendants maintained that the dystocia was not reasonably foreseeable and that they performed all proper maneuvers. In the defendants' view, the chest was compressing on the cord, causing the baby to be cyanotic after the head was delivered. They credited their skillful performance with the avoidance of a brain injury in an emergent situation.

While the jury was deliberating, the case was settled for \$80,000.

**Blood pressure late in pregnancy.** For nearly nine months the pregnancy was uneventful, but nine days before delivery of her first child, a 27-year-old immigrant from Vietnam was found by an obstetrician—a partner of the obstetricians whom she had seen until then—to have a significantly elevated protein level in the urine and slightly elevated, although still normal, blood pressure. A large weight



gain also had occurred. The same obstetrician handled the delivery. While in labor, the patient experienced an additional climb in blood pressure, to 186/120. Additional blood pressure readings were not taken during the period between 40 minutes before, and 45 minutes after, delivery. Severe edema in the lower limbs was observed.

The baby was born healthy. Two hours after delivery the mother suffered a stroke affecting the right side. She lost use of her right arm and eventually walked with a notable limp. She brought a malpractice action in New Jersey against the obstetrician.

An expert obstetrician-gynecologist testified for the plaintiff

that the high protein level, increase in blood pressure, and remarkable weight gain all signaled the possibility of pre-eclampsia. Stroke and seizure were identified by the expert as the major consequences of pre-eclampsia.

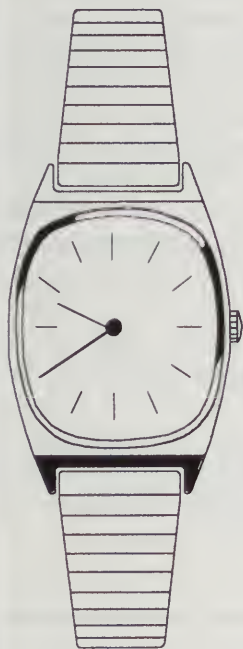
To depress the central nervous system and prevent stroke, the expert stated that magnesium sulfate should have been administered on the day of the last prenatal visit, on the following day, or at least during labor. A labor-and-delivery nurse further testified that she had suggested the use of magnesium sulfate after the last blood pressure reading before delivery, but that the defendant had advised her that this course was unnecessary.

Previously the plaintiff had been employed in Atlantic City as a blackjack dealer, earning \$34,000 per year. She contended that the stroke caused a significant loss of English-language proficiency, rendering her permanently unemployable. Unmarried, she subsequently gave birth to another child but stated that she could not cook, drive, perform many household chores, or subsist without two hours of help per day.

The defense argued that the language deficits probably were pre-existing. The jury found for the plaintiff and awarded \$1,162,000. □ James E. George, MD, JD, and Neil E. Weisfeld, JD, MSHyg

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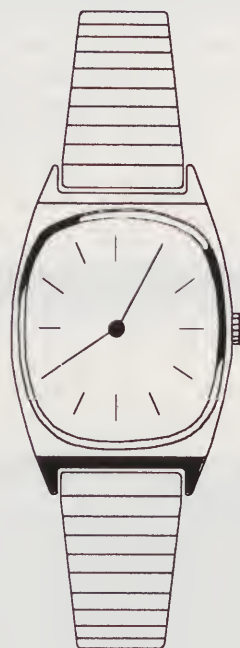
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# BOOK REVIEWS

## A MIRACLE AND A PRIVILEGE

*Francis D. Moore, MD.* Dr. Moore has been one of the great communicators in academic surgery. His autobiography will continue to enhance that reputation. What fascinated me about his story is that my generation of surgeons matured under the spell of his fascinating studies of body composition that are the basis for an enormous amount of current treatments in nutrition and intensive care. Yet, Dr. Moore obviously has as much pride in his ability as a clinical surgeon who effectively uses his skills at the table as in keeping in touch with the patient and the patient's family with empathy and warmth.

My own contact with Peter Bent Brigham residents confirms

that they respected their chief for being as much at home in the operating room and on the wards as in the laboratories. During his career at Peter Bent Brigham, Dr. Moore collected a star-studded team of attendings and trained an outstanding coterie of surgical residents who have spread throughout the United States and the world in academic positions.

Throughout the book, the reader is impressed with his warmth as well as with his many achievements in multiple fields. This is a volume that will be of major interest to any physician, but particularly to surgeons and surgical residents. □ Benjamin F. Rush, Jr, MD

## NEUROLOGY FOR PSYCHIATRISTS

*David Myland Kaufman, MD.* Philadelphia, PA, W.B. Saunders, 1995. First written in 1981 as an outgrowth of a course the author taught, and now in its fourth edition, this readable and useful book, *Neurology for Psychiatrists*, has gone beyond its original purpose as a vade mecum for that course. It is a comprehensive, readable, and clinically oriented textbook with coverage of the major categories of neurologic disorders, presented and discussed from both clinical diagnostic and disease entity perspectives.

This book provides abundant and useful illustrations; numerous test questions following each chapter and at the end of the book; and supplementary tables, figures, reference lists, and appendices that provide the reader with current, broad, and useful information in a format intended to teach and reinforce what has been studied. For the research-

oriented physician and the neurologist, Dr. Kaufman has updated this edition with chapter revisions including such topics as mitochondrial muscle disorders, NMDA receptors, minor head trauma, sleep disorders, advances in such prevalent disorders as Parkinson's and Alzheimer's diseases, and new diagnostic tests.

This book deserves top marks as a teaching textbook and as a reference book. For the academic and research neurologist, this book is an excellent review and summary of clinical neurology; the extensive and well-organized reference lists following each chapter provide neurologists with resources for more specialized and arcane information.

I like this book very much, and also liked its earlier editions. I recommend it highly for physicians requiring a current clinically oriented textbook of neurology. □ Daniel P. Greenfield, MD, MPH

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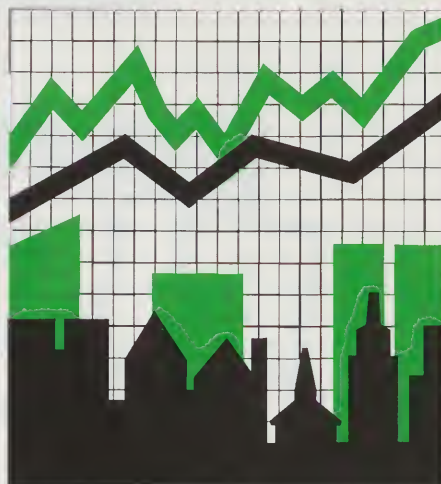
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# EDITOR'S DESK



## BANKING FOR HEALTH

Richard H. Bagger, writing as the Republican assemblyman from the 22nd district, outlined the development of health care "insurance" from its origins in Dallas in 1929 to the present. He pointed out the conflict between first dollar coverage, or payment for routine care, and the expansive health care technologies that increase costs to the employer, the source of much of the funding. This is the conflict between those without the sense of responsibility or concern about the costs and those who seek to limit costs to improve the success and stability of their businesses.

Assemblyman Bagger's recommendation: Medical savings accounts (MSAs).

MSAs have attracted diverse groups. According to *American Medical News* (AM News), about 1,000 companies either offer or are considering offering MSAs to their employees. The Arizona Health Alliance has 1,000 consumers enrolled. The United Mine Workers of America, Forbes Magazine, Golden Rule Insurance Company, and Lehman Brothers are some that have been depicted in the print media. According to a 1994 survey by Princeton consultants Foster Higgins, employer-based spending accounts are available at 45 percent of large companies, although only a small percentage of employees avail themselves of them. And new initiatives arise; as reported in *AM News* of December 25, 1995: "Boise, Idaho—In a first for a medical society, the Idaho Medical Association has endorsed a MSA from Blue Shield of Idaho for its member physicians and their employees. Idaho residents in the program will receive up to 8 percent payroll tax

savings." Government has considered the use of these tools for some time. Jersey City offers MSAs as one option for health care coverage to its city employees. Ada County, Idaho, is the first county to offer a similar plan. The majority of the states have considered them and at least ten states have made them law, with exemptions from state taxes. Dr. John Lanzilotta impressed some of our members with his presentation of the Commonwealth of Virginia law that makes MSAs available to "everyone in that state including Medicaid recipients and unemployed workers," as Louis L. Keeler, MD, wrote in September 1995. And many of us are aware that Congress, in considering the Balanced Budget Act of 1995, proposed giving MSAs equal tax relief to that given other employer-based health insurance.

Gail Wilensky, former head of the Health Care Financing Administration (HCFA), speaking at the annual meeting of the PIAA in Orlando last spring, noted, "It's one of the ugly facts of life about health care. Once you start using other people's money, the problem of trying to moderate spending or get spending right becomes difficult." She felt that the pace of spending would continue as long as it depended upon third-party payers, and she said that MSAs might offer a solution.

MSAs have been part of the congressional bills on Medicare reform, but were removed from Senate consideration by invocation of the "Byrd Rule," which allows any senator to raise a point of order against items in a budget bill that do not contribute to deficit reduction, and which requires a two-thirds vote to deny.

At the time of this writing, in late December, the issue is undecided and may be a dead issue during the tenure of this Congress. But MSAs still are worth discussing.

The basic framework of MSAs is simple. A specified amount of money is set aside, either by an employer (including governments) or by an individual, alone or as part of a family group. This fund would be used *de novo* to pay for routine medical expenses; subsequent expenses would be covered by an insurance policy with a deductible equal to the original amount, and at a low premium because of the high deductible. The two elements also could be grouped: one part would pay for the basic coverage and the other for the catastrophic coverage. If money is left in the primary account, it would be available, at some time, to the beneficiary. Some out-of-pocket expenses also can be expected. Other variations exist. All are geared to the same principle: instead of third parties being the payers for health care, as exists today for 80 percent of us, the patient would be both the giver and the recipient of these services. The Medicare type of MSA, by necessity, would be different from employer-sponsored ones, partly because individual, rather than group, coverage would be needed.

More than 90 percent of the employees of Golden Rule Insurance Company have opted for a medical plan that creates a \$2,000 MSA basic account, to be followed by a maximum of \$1,000 out-of-pocket, and then coverage by a catastrophic policy. The result to the company: about a 40 percent reduction in health care costs. Forbes has saved almost 30



percent since 1992 by its MSA plan, which rewards prudence on the part of the employee. The Arizona Health Alliance developed a high deductible policy. For \$80 a month, the 1,000 members were protected against costs exceeding \$5,000; and they were able to negotiate 40 percent discounts with local practitioners for cash payments without paperwork. Jersey City seems pleased with its plan. Singapore has had MSAs for a dozen years, with favorable experience.

Some of the benefits were presented to the MSNJ Board of Trustees late in 1995 by the Doctors Eck of Middlesex County, who also participated in a multi-county seminar last month. They noted that 95 percent of us would not spend the full amount of the initial account. This would cut back sharply on insurance costs, especially the paperwork and the personnel needed to deal with it. Abuse, chicanery, and outright fraud would be diminished because of the increased awareness by the patient of the costs. Because of this awareness, the patient also would participate more closely in the medical care.

John C. Goodman, president of the National Center for Policy Analysis in Dallas, listed several advantages in *The Wall Street Journal* of October 17, 1995. First, he suggested that making the initial part of an MSA plan an up-front benefit, even though it was paid for by another, would produce both prudence and the proper use of physicians' services, especially for children. Second, copayments would apply only to a narrow segment between the initial outlay and the catastrophic coverage, instead of relating to all bills across all levels of coverage. Third, "because MSA plans create more efficient and more appropriate incentives for patients, they are almost always able to offer their enrollees lower total out-of-pocket exposure than can conventional plans purchased with the same premium dollar."

He feels both the healthy and the sick do well with MSAs; the ones in neither camp may note some increases out-of-pocket.

MSAs are not an unalloyed joy to many. Certainly, insurance companies and some of their employees cannot be enamored by the anticipated decrease in premiums and in the numbers of required personnel. Yet, networks of physicians or other types of managed care can furnish the coverage for catastrophic events. Patients might try to avoid spending even an employer's money if part of it might accrue to them by foregoing needed, perhaps even essential, care. Or they might consider being treated by practitioners of alternative medicine, self-regulated and often averse to scientific scrutiny or publication.

Critics consider cherry-picking the most significant defect of MSAs. Healthy people probably are the most fortunate recipients of MSAs. If no medical expenses were incurred during the year, the allotted deposit would accrue to the benefit of the patient. This bonanza to the patient is upsetting to many who feel that the basic purpose of insurance would be sabotaged, i.e. that the sickest would not be paid for by the healthiest. The American Academy of Actuaries feels that a self-selection process favoring high deductibles for the healthy and low ones for the chronically ill would affect the plan adversely. Uwe Reinhardt, quoted in the *AM News*, calls it the "desocialization of health care spending." Others project a more favorable outlook when risks are spread among large groups, and the experience of some of these large groups seems to belie some of the criticism. But Medicare proposals may pose more of a problem, if individuals are given the ability to opt in and out without difficulty; at least that is one of the concerns. John Burry, CEO of Blue Cross Blue Shield of Ohio, staunch opponent of MSAs, also feels they would produce adverse

selection, although many of the Blues offer multiple plans that allow similar selection by the subscriber or (especially) the Blues.

Some additional questions about revenues have emerged. If the costs of full MSA programs are made tax-free, how much will it cost the government? If the costs are not to be tax-free, how much will it cost the employer, the patient, or both?

John Goodman considers the findings of the American Academy of Actuaries to favor MSAs, even for the elderly. A study by the Lewin-VIII consultants for a senior group concluded otherwise. But Goodman feels the Lewin study and others are flawed by their failure to understand MSAs and to include out-of-pocket expenses.

Medicine is split in its endorsements. The AMA, the American Academy of Family Physicians, the American Society of Internal Medicine and the American Association of Physicians and Surgeons have given support. The American College of Physicians, and the American Group Practice Association have indicated opposition. Bruce Vladek, architect of DRGs in New Jersey and present head of HCFA, members of the Hay Group, and others, either downplay the advantages of MSAs or are in direct opposition. Congress, at the time of this writing, has yet to decide, although by now it may have become moot. And so it goes. □ Howard D. Slobodien, MD

*The proverb warns that "you should not bite the hand that feeds you." But maybe you should, if it protects you from feeding yourself.*

Thomas Szasz,  
*The Second Sin*, 1973

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Bertolt Brecht,  
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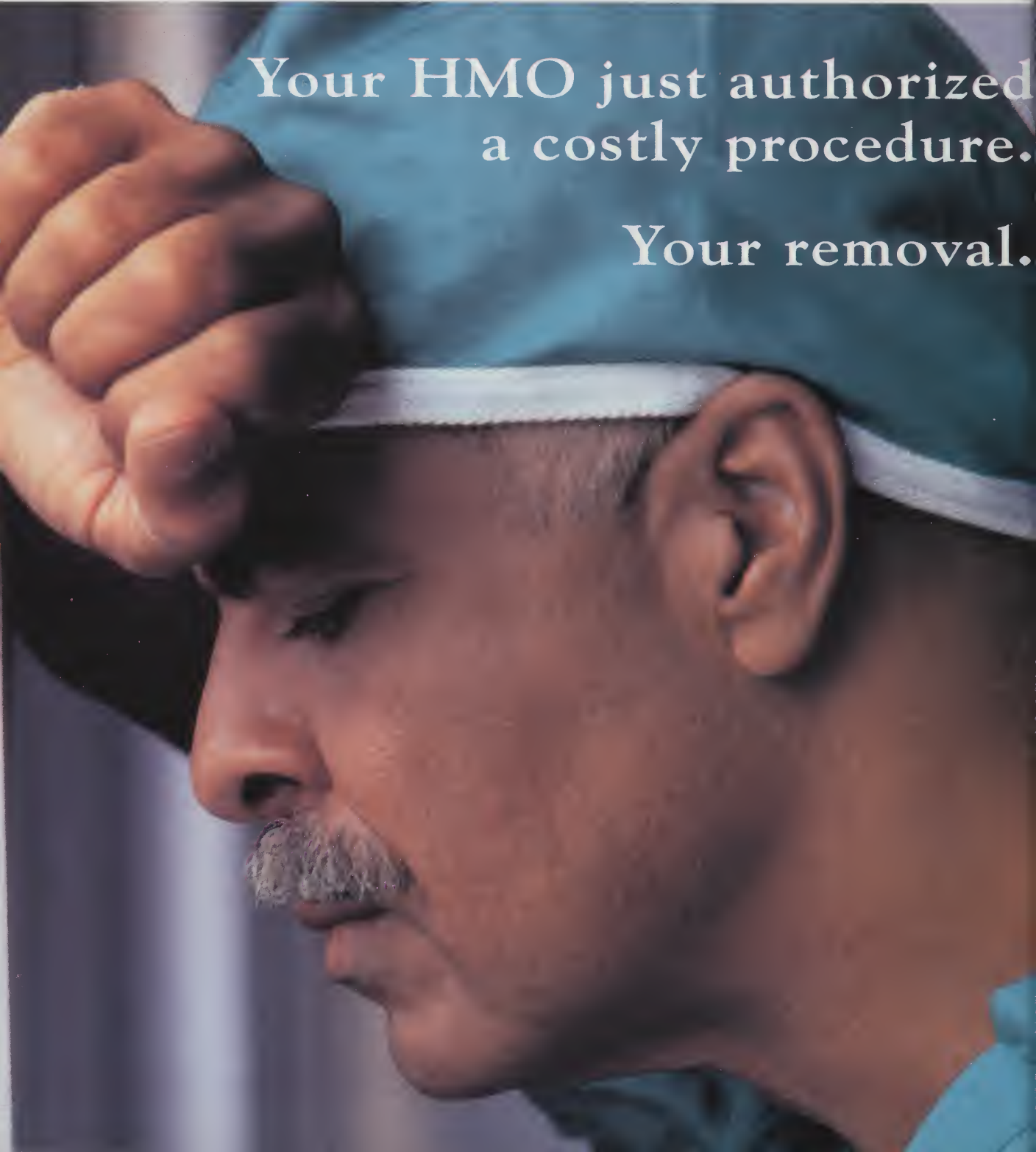
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# Responding to subpoenas and other demands for records and testimony

Steven I. Kern, Esquire

*Being served with a subpoena can be an intimidating event for a physician. This article provides a point-by-point guide to responding to subpoenas and other demands for records and testimony.*

Physicians routinely are required to provide copies of medical records and to give testimony concerning care they have rendered to patients. Unfortunately, some lawyers have abused subpoena powers to harass and intimidate physicians into providing testimony and records without appropriate reimbursement, without consideration for the physicians' convenience, and without regard for the legitimate rights of patients to maintain the confidentiality of health records.

This article will explain the rights and obligations of physicians to provide records and testimony and the concomitant responsibilities of the legal profession to obtain the same. It is the public duty of every person within the jurisdiction of a court to appear when commanded to testify. However, one must appear and testify and produce papers in court only when duly subpoenaed in a case pending before the court. To be valid, a subpoena must be issued in a manner and form consistent with constitutional and legislative authority. Failure to honor a valid subpoena can lead to contempt of court and severe sanctions.

## LEGAL OBLIGATIONS

The state Board of Medical Examiners (BME) has rules concerning the obligations of a physician to provide copies of the records to a patient and the patient's authorized representatives.

The rule generally provides that, upon written request, a physician must provide a copy of the patient's record to BME within ten days after notice, or to the patient or the patient's duly authorized representative within 30 days of receipt of the request. The physician may charge a fee of up to \$1 per page as compensation for copying and postage, with a minimum fee of \$10 and a maximum fee of \$100.

In lieu of providing copies of records, a physician may elect to provide a summary of the record, as long as that summary adequately reflects the patient's history and treatment and as long as the physician is not otherwise required to provide copies of the records, e.g. if required by subpoena. The physician may charge a reasonable fee for the preparation of the summary, but the fee may not exceed the cost permitted for photocopying and postage.

If, in the reasonable exercise of professional judgment, a physician has reason to believe that a patient may be harmed by release of the "subjective information contained in the professional treatment record or a summary thereof" the physician may refuse to provide this information. If the physician does so, he must provide the record, or the summary, "with an accompanying notice setting forth the reasons for the original refusal," to either the patient's attorney, another licensed health care professional, or the patient's health insurance carrier.

If the patient or the patient's subsequent treating health care professional is unable to read the treatment record, either because it is illegible or because it is prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

The fact that the patient owes the physician money on an unpaid balance is not an excuse to refuse to provide the treatment record, if the record is needed by another health care professional for the purpose of rendering care. It may, however, be a reason to withhold the information from the patient or the patient's attorney, if the record is needed for purposes of litigation.

When the records are to be released to someone other than the patient, the physician must first secure and maintain a current (usually signed within the



past six months) authorization, bearing the signature of the patient or the patient's authorized representative. The physician, therefore, must determine whether the person requesting the information is an authorized representative when the request is from a person other than the patient. An authorized representative is defined to include a person who has been designated by the patient or by a court to exercise the patient's rights to obtain records. This representative may be the patient's attorney or an agent of an insurance carrier with whom the patient has a contract that provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If a patient is a minor, a parent or guardian who has custody will be deemed to be an authorized representative.

BME also requires that the physician assure that the scope of the release is consistent with the request. Therefore, a patient's authorization to the insurance company to provide all records of treatment by that physician is not sufficient to authorize release of records that the physician may have obtained from another physician or from a laboratory.

BME also requires that records forwarded are sent to the attention of the specific individual identified in the patient's authorization, and that the material be marked "confidential."

In short, when releasing a patient's records, the physician must assure that the records provided are only those identified within the patient's current written authorization and that the records are only provided to the person or persons identified within the authorization.

## PRODUCING RECORDS

When a physician receives a subpoena for patient records, most physicians assume that the subpoena is legal and appropriate, and must be honored. In fact,

despite the official look of the document, a subpoena is just a piece of paper signed by an attorney. It usually has not been reviewed by a judge and has not undergone any official review or inspection. To determine the validity of the subpoena, the physician should undertake a five-step analysis.

**Step 1: What court is involved?** The rules governing subpoenas vary with the court involved and whether the matter involves a civil or criminal case. To determine the type of case and the court, examine the caption. It should tell you the name and type of the court—state or federal—and the nature of the action—civil, criminal, or administrative. This article addresses only actions in New Jersey state courts. Other states and federal courts have different rules; in such cases, an attorney should be consulted before responding to a subpoena.

**Step 2: Where are you to appear?** If you are being subpoenaed to give testimony at a court for a trial, the rules require that you appear at that trial, anywhere within the state, upon the payment of a witness fee and mileage. If your testimony is required by a state agency, you also may be required to appear anywhere in the state, depending upon the jurisdiction of the agency and the scope of the agency's powers. If you are being subpoenaed to give a deposition, the rules are far more limited. You should not have to appear beyond the county in which you live or work, and your testimony should be taken at your convenience. Moreover, you may be entitled to substantial fees, including reimbursement for time lost from employment, rather than merely payment of a witness fee and mileage. The language of the subpoena should tell you whether you are being subpoenaed to give testimony in court or for purposes of discovery.

**Step 3: Why are you being subpoenaed?** If you are being

subpoenaed to a trial only to provide copies of records, you may be able to send a custodian of the records, such as your office manager. If you are to testify solely as to factual issues, your testimony may be compelled, and your ability to obtain compensation for your time may be severely restricted. By contrast, if you are being subpoenaed to give expert testimony, your testimony may not be compelled and your ability to obtain compensation for your time is substantially enhanced.

If only your records are being subpoenaed, beware. Records may only be subpoenaed for trial or at the time of a deposition, at which your testimony will be taken. Some attorneys, seeking to avoid payment to you, will attempt to obtain records by issuing an invalid subpoena duces tecum for your medical records to be produced. If the records are subpoenaed, other than for trial, you need not provide them, other than during the course of a deposition.

**Step 4: Were you properly served?** A subpoena is enforceable only if it is properly served. The Rules of Court describe in detail how a subpoena must be served. If the matter at issue is a civil action in New Jersey, the Rules Governing Civil Practice require that a subpoena be served upon you by a person 18 years old or older. Service can be made by delivering a copy of the subpoena to you together with an appearance fee (depending upon mileage somewhere between \$5 and \$25). If the case is a criminal case, the fee need not be paid until your testimony is concluded.

**Step 5: Is the subpoena properly executed and signed?** For a subpoena to be valid it must be properly created. The subpoena must be signed either by the clerk of the court or by an attorney or party in the name of the clerk. It must state the name of the court and title of the action. It also must command each

person to whom it is directed to attend and give testimony at the time and place specified.

## YOUR RIGHTS AT TRIAL

If you are being subpoenaed as a fact witness to provide testimony at a trial, your rights are very limited. Except for receipt of your appearance fee and mileage, you are obligated to appear in response to the subpoena. You should contact the attorney who issued the subpoena (not the county clerk whose name the subpoena is issued in—the attorney simply signs the subpoena using the clerk's name) and attempt to work out a time mutually convenient for your appearance, or agree to be available on one or two hours' notice. If the attorney will not cooperate, attempt to reach the trial judge or the civil assignment judge for the county in which the trial is taking place, and ask the judge to intervene.

If your testimony is required at trial, some judges will be willing to accommodate a physician's reasonable schedule and most attorneys will work with you to place you on notice, rather than requiring you to sit through hours or days of other people's testimony. You should speak with the attorney who has subpoenaed you and attempt to work out a reasonable schedule. Note, however, that courts have held that an on-call subpoena creates a continuing duty to appear and that a person is not released from that obligation unless a court directs. At least one court has held that a three-week, on-call subpoena issued by a prosecutor to secure attendance of police officer witnesses in criminal prosecutions was not an unreasonable burden or restriction on the officers' movement.

If you are subpoenaed solely to provide records, at trial, you may be able to send, in your place, the person in your office who is the custodian of the records, or, with the consent of the parties, a certified copy of the original re-

cords alone. Check with the attorney issuing the subpoena. If the attorney is not acting reasonably, by motion, you may seek to quash or modify the subpoena. To do so, you need to show that compliance would be unreasonable or oppressive. In a civil case, you also can ask the court to condition the subpoena upon payment of the reasonable cost of producing the subpoenaed records. If the physician must appear, that cost could include the value of his time away from the office.

A physician cannot be compelled to provide expert opinion at a trial. The law is clear that expert opinion belongs to the physician and the physician need only provide it if the physician agrees to do so. The physician also is entitled to charge for expert testimony. If the attorney desires expert testimony, the physician and the attorney should agree, in advance, on the amount of money to be received (or the hourly rate). Beware, however, that once a physician agrees to act as an expert, and certainly once he has provided an expert report, failure to appear at a trial could result in legal action against the physician if the case is lost because there was no expert evidence. Of course, you can only be required to testify as to your honest opinions and conclusions.

A gray area exists when a treating physician is asked to render opinion testimony. To the extent that the treating physician is asked to merely recount the opinions he formed during the course of providing treatment, he may well be considered a fact witness, not entitled to expert witness fees. However, when the testimony sought goes beyond a factual recounting of the opinions relied upon by the treating physician for purposes of rendering that treatment, the treating physician may well become an expert and be entitled to additional compensation.

A treating physician should dis-

cuss with the patient's attorney the scope of testimony and whether the physician will be compensated as an expert, before providing testimony. If the attorney insists on calling the physician solely as a fact witness, the physician may well choose to carefully limit the scope of testimony to a recitation of the factual matters set out in the records.

## THE DEPOSITION

The most abused use of the subpoena is to obtain patient records from the physician, without payment to the physician. While a patient or a patient's representative may obtain copies of the patient's records, the patient's adversary has no similar recourse. To obtain patient records, the attorney either needs the patient's consent, or must apply to the court for an order. Not infrequently, however, attorneys seek to obtain these records by subpoena duces tecum. A subpoena duces tecum is a subpoena for records. Its only legal use is to compel production of those records at trial or at a deposition. It cannot be used to compel production of records to an attorney's office or at any other time. Therefore, the only time a physician should turn over patient records, other than to the patient or the patient's duly authorized representative, is when a patient release accompanies the request, or at a duly noticed deposition.

To get around this rule, unscrupulous attorneys, threatening the inconvenience of a deposition, will improperly subpoena records and then give the physician the alternative of merely sending a copy of the records. A physician should not accept this alternative, absent a release by the patient. The release of confidential patient records, without patient authorization, or subject to a valid subpoena, is improper, and can lead to loss of license and to a civil suit. Rules of Court require attorneys to obtain records in accordance with precisely pre-



scribed means. Unfortunately, those rules are not always followed. Acting at the behest of an attorney who did not follow the rules may be no defense to the physician.

If the physician is testifying as either an expert witness or as a treating physician, the physician is entitled to be paid for time. The party taking the deposition (usually the party adverse to the physician's patient) will be required to pay the physician a "reasonable fee" for the appearance. If the parties cannot agree upon a reasonable fee, the court will determine that fee. The fee for the physician's preparation for the deposition, however, will be paid by the proponent of the witness (usually the patient's attorney). If the deposition is taken at a place

other than the physician's residence or place of business, the party taking the deposition also must pay for the witness' travel time and expenses.

If the physician is neither testifying as an expert nor as a treating physician, but merely has factual information about the case, the physician is entitled to reimbursement of out-of-pocket expenses and loss of pay, if any, incurred in attending the deposition. The deposition must be taken at a reasonably convenient time and only in the county in which the physician resides, is employed, or transacts business in person.

### CONCLUSION

Physicians have legal obligations to give testimony in actions in which they have personal

knowledge. The rights of physicians to compensation and to avoid inconvenience depend upon the nature of the procedure, the type of information sought, and the ability of physicians and attorneys to cooperate. Before responding to any subpoena or demand for records, physicians must understand what is required. Physicians cannot rely upon the words of the subpoena but must independently assess the validity of the demand. ■

Mr. Kern is a principal with Kern Augustine Conroy & Schoppmann. Address reprint requests to Mr. Kern, Kern Augustine Conroy & Schoppmann, 1120 Route 22 East, Bridgewater, NJ 08807.

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# Case report: Neurocysticercosis in pregnancy

Philip W. Paparone, DO  
Richard A. Menghetti, MD

*The signs and symptoms of neurocysticercosis range from a single convulsion to coma and death. Medical treatment with new anticysticercus drugs can be effective, while surgery may be indicated in selected cases. This report describes a case of neurocysticercosis in pregnancy.*

Neurocysticercosis is an infection of the central nervous system (CNS) with the tissue-invasive larval stages (cysticerci) of the pork tapeworm, *Taenia solium*. It is the most common parasitic infection of the CNS,<sup>1,2</sup> where larvae invade parenchyma, the subarachnoid spaces, and the ventricular system, causing seizures, hydrocephalus, and other neurologic dysfunction.<sup>1</sup> During the past two decades, neurocysticercosis has been increasingly recognized through improved brain imaging by computed tomography (CT) and magnetic resonance imaging (MRI) scans. The disease used to be rare in the United States. However, its incidence has greatly increased since the mid-1970s, particularly among immigrants from endemic countries, e.g. Mexico, China, India. Some experts believe that its prevalence has been significantly underestimated.<sup>3,4</sup> This report describes neurocysticercosis in a pregnant woman and highlights the challenges posed by the disease.

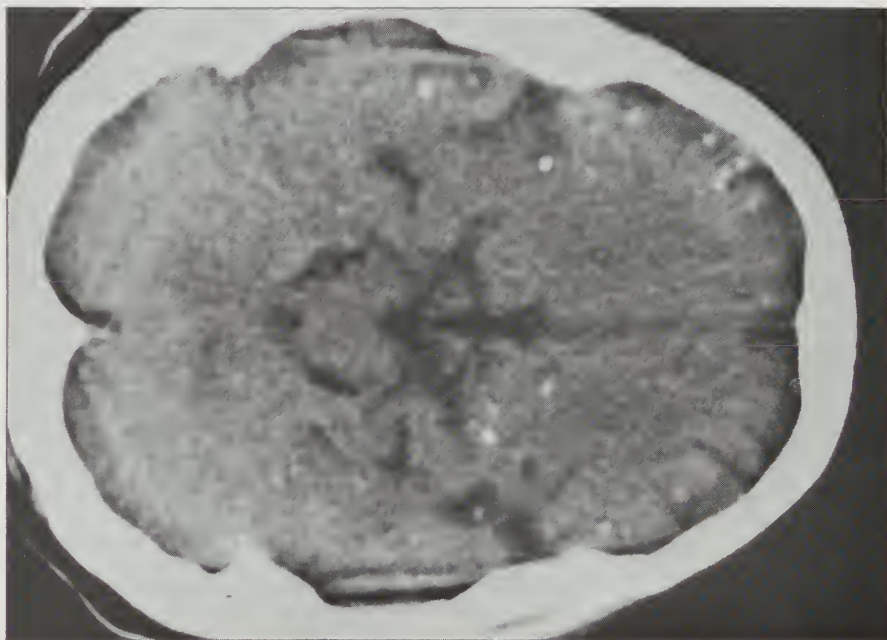
## CASE REPORT

On May 11, 1994, a 17-year-old pregnant woman of Mexican ori-

gin presented to the emergency room of Shore Memorial Hospital, Somers Point, after having an apparent grand mal seizure that lasted 15 minutes. She had a history of cysticercosis, and was five weeks pregnant. She had been in the United States for 18 months. On physical examination, she was alert and feeling fine and without headache. Her neck was supple. Her pupils were equal and reac-

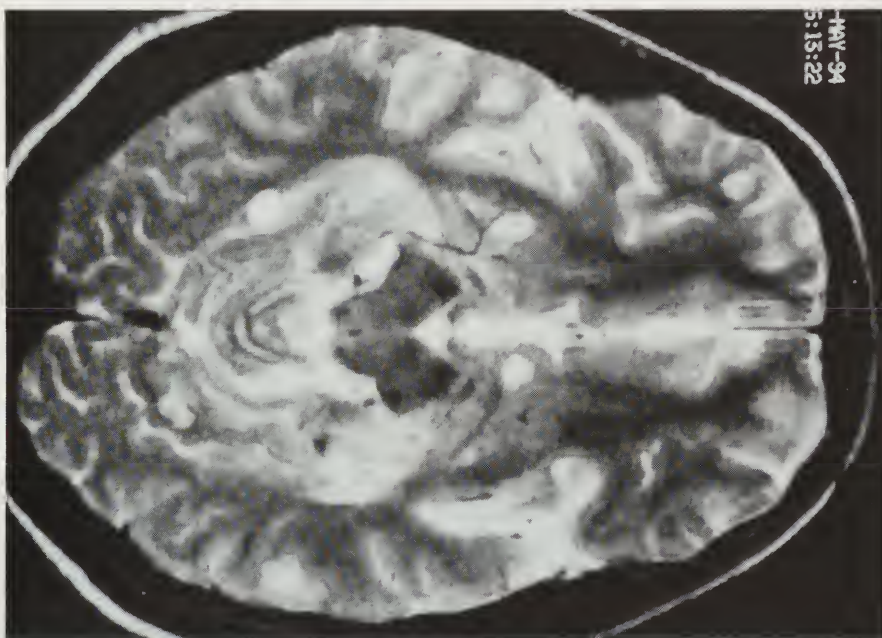
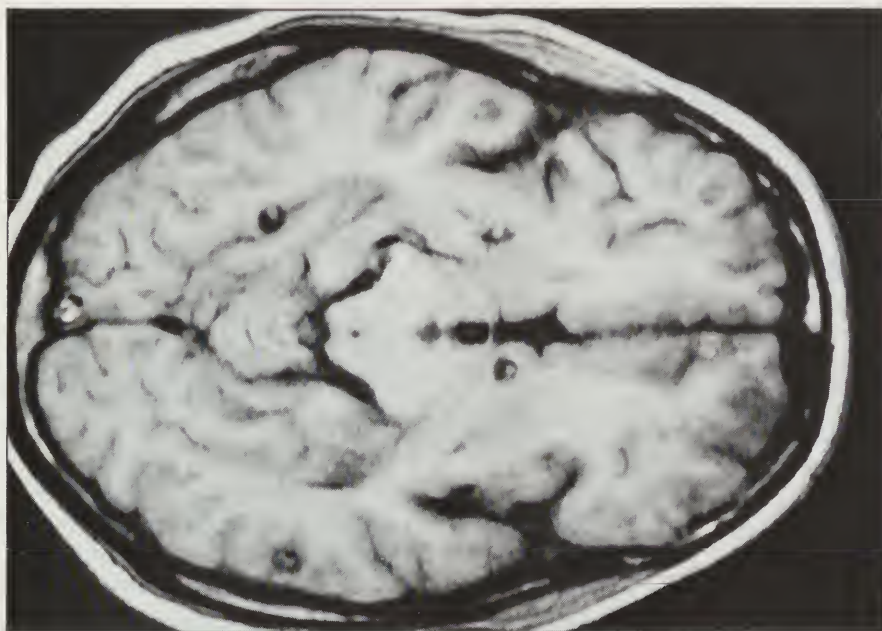
tive to light, and her extraocular muscles were intact. Motor and sensory functions and deep tendon reflexes were normal. She had clear lungs, normal sinus rhythm, and a soft abdomen. After 30 minutes' observation in the emergency room, during which time she did not have a seizure, she was admitted to the hospital and given phenytoin (600 mg daily) and phenobarbital (100 mg three times daily).

Laboratory values were essentially unremarkable. Noncontrast CT examination of the brain showed multiple punctate brain parenchymal calcifications, compatible with cysticercosis (Figure 1). MRI examination demon-



**Figure 1.** Noncontrast CT image showing multiple punctate brain parenchymal calcifications, compatible with cysticercosis. Note visualization of dead calcified cysticercus larva (scolex).





**Figure 2.** MRI images showing multiple randomly distributed cystic lesions, predominantly in the distribution of the cerebral sulci in the subarachnoid space, but also within the parenchyma (top, T1 region; bottom, T2 region). Note that the various stages of the larvae are better seen on MRI, as compared with CT imaging (Figure 1).

strated multiple randomly distributed cystic lesions, predominantly in the distribution of the cerebral sulci in the subarachnoid space, but also within brain parenchyma, measuring up to 8 mm in maximal transverse diameter (Figure 2). The cystic lesions were hypodense on T1 with a nidus of central hyperintensity. With progressive T2 weighting, the fluid component of the cysts showed a hyperintense

signal equal to the adjacent CSF and a central hypointensity. There was an insignificant perilesional inflammatory reaction. No evidence of obstructive hydrocephalus or significant mass effect was found on CT or MRI.

Although the punctate calcifications found on CT scan were suggestive of nonviability, MRI features correlated with cystic cavities with a central scolex/larva, thus active infection could

not be excluded from the diagnosis. Clinical correlation with immunologic markers/titers then was recommended. On hospital day 4, serum specimens were collected for analysis, and the patient was discharged from the hospital with a presumed diagnosis of neurocysticercosis. She was placed on oral phenytoin (100 mg three times daily). The results of serologic studies obtained shortly thereafter were positive for cysticercosis, with a high titer of 1:1280 ( $\geq 1:160$  interpreted as presumptive positive).

On June 3, the patient started anticyclicercus therapy with praziquantel (1,050 mg three times daily for 21 days) after signing a release from any potential adverse effects on the fetus. Four days later, the patient had another seizure, and returned to the emergency room. Findings of the physical examination were normal. Laboratory values were essentially unremarkable; only a low level of uric acid (1.3 mg/dL; normal range, 2.2-7.7 mg/dL) was found. Anticonvulsant therapy with phenytoin (100 mg three times daily) was augmented with an additional anticonvulsant drug, carbamazepine (200 mg twice daily), to be taken on alternating days, and the patient was continued on praziquantel. No further seizures occurred.

One month after completing the 21-day course of praziquantel, the patient had only brief spells of mild confusion on occasion. At this time, positive findings of the immunoblot assay conducted by the Centers for Disease Control further confirmed the clinical diagnosis. Subsequently, stool specimens from the patient and her husband were examined for the presence of ova and parasites. All findings were negative for intestinal *T. solium* infection. In addition, serologic analysis of a blood specimen from the husband was negative for cysticercus antibodies.

The patient continued to improve with no recurrent seizures.



She was maintained on phenytoin (100 mg three times daily alternating with 100 mg twice daily) and carbamazepine (200 mg twice daily). Her pregnancy ran a normal course, and at term she delivered vaginally a normal healthy baby girl (2.5 kg) without any signs of congenital infection or adverse consequences of praziquantel therapy. The birth took place at home, after which the patient and her baby were hospitalized for two days for post-delivery care. The patient suffered no adverse consequences during or after the delivery that were associated with *T. solium* infection. The only abnormal findings in the baby were in her blood chemistry, which revealed slightly low values for red blood cells (3.62 M/UL; normal range, 4.20-6.00 M/UL), hemoglobin (12.8 g/dL; normal range, 17.0-23.0 g/dL), hematocrit (36.0%; normal range, 50.0-62.0%), and mean corpuscular volume (99.4 fL; normal range, 103.0-123.0 fL), as well as slightly high values for mean corpuscular hemoglobin (35.3 pg; normal range, 27.0-33.5 pg) and red cell distribution width (15.9%; normal range, 11.5-15.0%). Gross examination of the patient's placenta showed no abnormalities.

The patient has experienced no further seizures to date, and is maintained on phenytoin (100 mg three times daily) and carbamazepine (200 mg twice daily).

## DISCUSSION

Neurocysticercosis usually is acquired abroad. However, locally acquired cases in native patients with no history of travel to endemic areas and, in some cases, no history of pork consumption as well, have occurred in diverse locations in the United States.<sup>5-7</sup> This potentially life-threatening parasitic infection can pose a diagnostic dilemma, as there are no characteristic clinical manifestations. Symptomatology may range from a discrete neurological disturbance to the most dramatic brain disorder.<sup>8,9</sup> A heightened

index of suspicion is a critical first step in establishing the diagnosis, which should be considered in patients with seizures and radiologic evidence of cystic brain lesions. Routine laboratory studies usually are unremarkable.<sup>10</sup> Modest peripheral leukocytosis or, occasionally, eosinophilia may be found, but the latter may reflect coinfection with other parasites. The electroencephalogram may reveal focal or generalized slowing or spike or sharp wave discharges, or it could be normal.<sup>1</sup>

CSF examination is useful in determining active inflammation and in testing for anticysticercosis antibodies. However, CSF findings vary considerably and depend, in part, on whether cysticerci are present in the cerebral parenchyma or in the ventricular or subarachnoid spaces. The CSF may be normal or show elevated protein content, hypoglycorrhachia, or pleocytosis. About one-half of the patients seen by Sotelo had elevated CSF protein and/or more than 6 leukocytes/mm<sup>3</sup>.<sup>11</sup> The pleocytosis is predominantly mononuclear, but neutrophils or eosinophils can be present. The protein content has been as high as 1.6 g/dL in an occasional patient.<sup>1</sup>

Neuroimaging studies are the most sensitive detectors of the location and stage of infection. CT scanning can help identify parenchymal calcifications associated with neurocysticercosis. Intraventricular cysts may be missed, but these can be identified by MRI, which can detect signs of cyst degeneration and mineralization as well as parasitic inflammation. Thus, MRI is a powerful diagnostic tool, not only for evaluating neurocysticercosis but also for demonstrating the presence of intraventricular cysts. Precontrast MRI provides enough information for a presumptive diagnosis. However, contrast imaging is more useful in patients whose clinical or precontrast MRI studies show meningitis, granu-

lomatous lesions, or cysts with surrounding edema.

Until the 1980s, neurocysticercosis had no specific pharmacologic treatment. Surgery and steroids were the only medical alternatives. Surgical therapy now generally is reserved for patients with fourth-ventricular cysts, spinal lesions, or large mass lesions that obstruct CSF flow or simulate neoplasms; patients with progressive hydrocephalus may respond favorably to ventriculoperitoneal shunt placement, but the long-term prognosis for such patients appears highly variable.<sup>12</sup> Inactive disease, as indicated by parenchymal calcifications, requires only symptomatic therapy such as anticonvulsants for seizures.

Now that the safety and efficacy of chemotherapeutic agents have been established, medical treatment is possible in most cases.<sup>13</sup> Therapy must be individualized according to the location or activity of the cysticerci and the nature of the neurologic disorder. At present, two anticysticercus drugs, praziquantel (isoquinoline) and albendazole (benzimidazole), are widely used in the treatment of active disease evidenced by arachnoiditis or the presence of parenchymal cysts.<sup>8,13-15</sup> Both drugs have demonstrated similar equivalent efficacy and greatly improve the therapeutics of neurocysticercosis.<sup>14,15</sup> The scheme of therapy now in use has been empirically established, and the establishment of optimal doses and length of drug therapy awaits further study.

The pregnant woman and her unborn child are vulnerable to the potential side effects of various anthelmintic drugs, including praziquantel and albendazole. Generally speaking, caution should be exercised in prescribing these drugs during pregnancy, especially during the first trimester. The possible risks to the pregnant patient and the fetus always must be weighed against the like-



ly deleterious consequences of the infection. Whenever possible, use of anticysticercus drugs should be delayed until delivery has taken place. If chemotherapy clearly is indicated, careful selection of the safest available drug is vital. Use of albendazole during pregnancy remains controversial;<sup>16,17</sup> thus, praziquantel is preferred. ■

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# Unilobar intrahepatic lithiasis 22 years after cholecystectomy

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*Complaints of right upper quadrant pain, jaundice, and fever in the postcholecystectomy patient provide the physician with a challenging diagnosis. This case concerns a patient with intrahepatic lithiasis and fibrotic atrophy of the right lobe 22 years after open cholecystectomy.*

A 48-year-old Hispanic female presented with a 4-year history of paroxysmal right upper quadrant pain associated with fever, jaundice, nausea, and vomiting. These episodes, lasting from 5 to 14 days, occurred once or twice each year. Her most recent exacerbation of symptoms was three weeks prior to admission. At the time of presentation, the patient reported a weight loss of ten pounds over the past month with anorexia, but was otherwise asymptomatic. The patient had been admitted to another hospital two years prior to admission for similar complaints. At that time, percutaneous liver biopsies revealed nonspecific feathery degeneration with mild to moderate lymphocytic and polymorphonuclear infiltration. All viral hepatitis screens were negative. A diagnosis of mild active hepatitis, nonspecific type, was made. Recently, these episodes have increased in frequency and in resistance to supportive therapy. The patient was referred to our institution for further workup. Significant medical history includes a cholecystectomy performed 22 years ago. Operative records of the open cholecystec-

tomy performed in Brazil were not available. There was no history of alcohol abuse, drug abuse, or previous blood transfusion. Family history was noncontributory. Physical examination was within normal limits; fever, jaundice, and hepatomegaly were not appreciated. Routine chemistries and liver function tests were normal except for an alkaline phosphatase of 239 U/L (normal = 20-70 U/L).

Using biliary manometry, resting intraductal pressure was measured at 62 mmHg (normal = 0-4 mmHg). Slight ectasia of the common bile duct and delayed contrast clearance were appreciated via endoscopic retrograde pancreatography (ERCP). Within 12 hours post-ERCP, the patient developed fever, jaundice, vomiting with right upper quadrant tenderness, and black, tarry stool. Alkaline phosphatase was found to be 347 U/L, serum gamma-glutamyl transpeptidase (sGGT) was 570 U/L (normal, female = 8-40 U/L), ALT was 68 U/L (normal = 8-20 U/L), AST was 347 U/L (normal = 8-20 U/L), total/direct bilirubin was 0.8/0.3 (normal = 0.2-1.0/<0.2), and white blood cell count was 9,600 cells/cc (normal = 4,800-10,000

cells/cc). Ultrasound of the upper abdomen revealed atrophy of the right hepatic lobe, evidenced by a definite rightward shift of the ligamentum teres fissure, and isolation of dilated right intrahepatic bile ducts. Computed tomography (CT) scan corroborated these findings. Repeat ERCP confirmed noncommunication of the right biliary system with the remainder of the biliary tree. The patient was referred to surgery and then scheduled for laparotomy.

There was remarkable fibrotic atrophy of the right hepatic lobe with significant compensatory hypertrophy of the left lobe. The entire surface of the right lobe possessed a rough, gritty texture with whitening and thickening of the capsule. The bile duct was isolated. There was no gross abnormality noted. Intrahepatic extension of the dissection revealed stricture of the right hepatic duct with proximal dilatation. There was no abnormality of the left biliary tree appreciated. Intraoperative cholangiography revealed obstruction of the right intrahepatic duct at or near the porta hepatis. Based on these findings, a right hepatic lobectomy with portal dissection was performed.

The specimen was amber in color and nodular, with a brownish-yellow capsule covered by hard, fibrous adhesions. The right lateral branch of the biliary tree was occluded with multiple small brownish-black concretions



measuring 1 to 3 mm in diameter. Microscopic examination demonstrated numerous intraductal bile calculi and chronic inflammatory reaction in the walls of the bile duct. The major intrahepatic duct tributaries were dilated, consistent with extra-hepatic biliary obstruction.

Postoperatively, the patient developed a subphrenic abscess, which was drained percutaneously. Cultures taken from the abscess grew out *Klebsiella oxytoca*, a gram-negative enteric rod. After a course of antibiotic therapy, the patient was discharged without further complications. Seventeen months postoperatively, the patient remains asymptomatic and all liver function tests are normal.

## DISCUSSION

Postcholecystectomy patients with right upper quadrant pain, fever, jaundice, nausea, and vomiting provide diagnostic challenges. Workup involves both noninvasive and invasive procedures, such as ultrasound examination, CT scan, ERCP, and

biliary manometry. There are multiple etiologies of biliary stasis, lithiasis, and obstruction. Iatrogenic causes, as suggested by the patient's history, include accidental ligation of a normal or aberrant hepatic duct, disruption of the ducts, or manipulation of the surrounding structures.<sup>2-4</sup> Occlusion of the portal venous branches or ligation of arterial supply also cause fibrotic atrophy.<sup>5</sup> This patient developed symptoms and signs of biliary obstruction 18 years after open cholecystectomy. Initial findings on ultrasound, CT, and ERCP indicated noncommunication of the right duct with the remainder of the biliary tree. Operative findings of stricture and proximal dilatation of the right hepatic duct are consistent with iatrogenic causes of biliary stasis and fibrotic atrophy. The pathology sections of the right hepatic lobe confirmed lithiasis and chronic inflammatory changes with resultant fibrosis. ■

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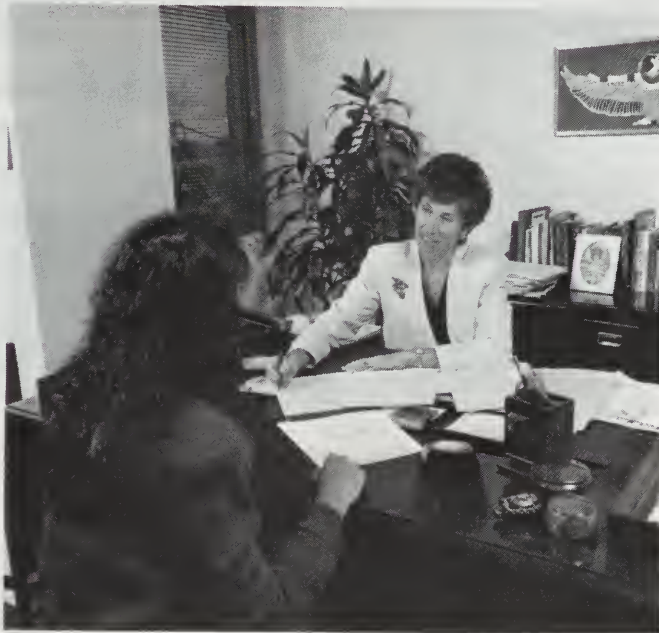
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# Case report: Post-transfusion purpura

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*Post-transfusion purpura (PTP) is a rare disorder characterized by the abrupt onset of severe thrombocytopenia following a blood transfusion. We describe a case of PTP in a patient treated with plasmapheresis, noting that this is an uncommon but treatable disease entity.*

**P**ost-transfusion purpura (PTP) is a relatively rare but well-described entity characterized by the sudden onset of a severe thrombocytopenia one to two weeks after a transfusion of blood products. This syndrome is associated with the presence of platelet-specific antibodies against alloantigens on transfused platelets. We report the case of a patient with PTP successfully treated with plasmapheresis.

## CASE REPORT

A 70-year-old woman presented with abdominal pain consistent with acute diverticulitis. Laboratory evaluation revealed a mildly elevated white blood cell count; the platelet count was 238,000 per  $\text{mm}^3$ . The past medical history was notable for one pregnancy and the absence of prior blood transfusions. On the third day after admission the patient developed a significant hemorrhoidal bleed. The patient required surgical intervention undergoing hemorrhoidectomy and transfusion of five units of packed red blood cells. The patient tolerated the procedure well and was discharged five days later. The following day, six days post-trans-

fusion, the patient returned to the hospital with rectal bleeding. The platelet count was 4,000 per  $\text{mm}^3$  with a hemoglobin of 10.5 g per deciliter and a hematocrit of 31.4 percent. The peripheral blood smear showed decreased platelets but no evidence of hemolysis; prothrombin time, partial thromboplastin time, thrombin time, fibrin degradation products, and fibrinogen were all normal. Blood cultures remained negative. The patient had been on hydrochlorothiazide/triamterene for years and during her recent hospitalization she received ampicillin/sulbactam, digoxin, ranitidine, heparin flushes, and acetaminophen/oxycodone. All medications were discontinued. The patient was given intravenous corticosteroids and transfused random donor platelets. Fifteen hours later her platelet count had dropped to 2,000 per  $\text{mm}^3$  and the hematocrit was 26 percent. Bone marrow aspirate revealed megakaryocytic hyperplasia and decreased iron stores. Platelet antibody screening indicated the presence of anti-PI<sup>A1</sup> antibodies.

The patient was started on plasmapheresis with fresh frozen plasma exchange. Plasmapheresis was performed on three con-

secutive days and by the second course the platelet count had increased to 47,000 per  $\text{mm}^3$ . The platelet count normalized five days after the initiation of plasmapheresis.

## DISCUSSION

In 1959, Zucker described a patient who acutely developed a severe thrombocytopenia with hemorrhagic symptoms after receiving a blood transfusion but no alloantigen was identified.<sup>1</sup> Concurrently, van Loghem reported a similar patient and defined the platelet-specific alloantigen, Zw<sup>a</sup>, in her serum.<sup>2</sup> Two years later, Shulman reported two similar cases and suggested a causal relationship between the severe thrombocytopenia and the platelet alloantibody stimulated by the transfusion.<sup>3</sup> They termed the syndrome PTP. The platelet antibody termed anti-PI<sup>A1</sup> was shown to be the same as van Loghem's anti-Zw<sup>a</sup>. Since the first case was described, approximately 200 cases have been reported.

As observed in this report, profound thrombocytopenia generally develops seven days after blood transfusion. Typically, platelet counts precipitously fall to less than 10,000 per  $\text{mm}^3$ , and there is a sudden appearance of purpura, petechiae, and mucosal hemorrhages. Bleeding from puncture sites and operative wounds may follow; often hematuria or gastrointestinal hemorrhages have been reported. Approximately 90 percent of all



cases are reported in women previously sensitized by pregnancy or prior blood transfusion. This patient had no prior history of blood transfusions, but had delivered one child approximately 36 years ago. The ages of reported patients range from 16 to 80 years, with the majority being in their sixth and seventh decade. Bone marrow aspirates usually reveal normal or increased megakaryocytes and coagulation studies are normal.

The occurrence of an unprecedented thrombocytopenia in a woman over 40 years of age after a recent blood transfusion is strongly indicative of PTP. However, it is a diagnosis of exclusion; therefore, other causes need to be considered, e.g. disseminated intravascular coagulation due to sepsis, hypoxia, tissue necrosis, or transfusion reaction; bone marrow hypoplasia; drug-induced immune thrombocytopenia (including heparin-induced thrombocytopenia); thrombotic thrombocytopenia purpura, and other potential causes of platelet destruction.

The definitive diagnosis involves the demonstration of both circulating platelet-specific alloantibody and the absence of the appropriate platelet antigen on the patient's platelets following recovery. This patient had anti-PI<sup>A1</sup> antibodies, which are found in 85 percent of the cases. Other platelet-specific antigens also have been reported.

PTP is a self-limiting condition, therapeutic intervention is indicated if the thrombocytopenia is so significant as to possibly result in cerebral hemorrhage. The duration of severe thrombocytopenia in PTP is variable and untreated may resolve in 5 to 120 days. However, PTP carries a mortality rate of approximately 10 percent.

Corticosteroids have been beneficial in several reports.<sup>4,5</sup> However, their use usually does not lead to a resolution of the thrombocytopenia. Mean recov-

ery time of the platelet count after initiating steroid therapy is approximately 20 days.<sup>6</sup> Splenectomy has been reported to be effective in one reported case of refractory PTP.<sup>7</sup> Treatment with plasmapheresis or intravenous high-dose IgG appear to be the best treatment modalities.<sup>8</sup> These interventions tend to induce a rapid rise in platelet counts limiting the need for repeated transfusions.<sup>9</sup> The response to plasma exchange may be more rapid.<sup>10,11</sup> The possible mechanism by which plasmapheresis is effective in PTP is that the isoantibodies provoked by a platelet antigen in the transfused blood are removed by the procedure. Platelet transfusions, whether they are random-donor or matched for platelet-specific antigens, may prolong the period of thrombocytopenia.

The use of blood products is commonplace today. This report brings attention to a treatable disease entity that, although rare, should always be considered in the differential diagnosis of thrombocytopenia. ■

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# Issues in the medical care of the lactating woman

Deena R. Zimmerman, MD, MPH

*Breastfeeding provides health advantages for mothers as well as babies, and it should be encouraged by physicians who care for women in the childbearing years. Accurate medical information regarding lactation will facilitate this process as will referral to support services.*

**B**reastfeeding is the optimal form of infant feeding for mother and baby. Since it often is expressed as "the optimal form of infant nutrition," breastfeeding management is delegated to the pediatrician. However, breastfeeding provides health advantages for mothers as well as babies and it should be encouraged by all physicians who care for women in the childbearing years.<sup>1</sup> The goal of this article is to review situations in which lactating mothers interact with the medical profession and how physicians can care for them with sufficient knowledge to "first, do no harm."

For women who have chosen to breastfeed, it is a special time in their lives and in their relationships with the babies they are nursing. Ending this relationship involuntarily is traumatic from the maternal perspective and should only be advocated by physicians when truly medically necessary and with appropriate support.

**Breastfeeding duration.** The first important question to ask the mother is if she is nursing. The ideal is for women to breastfeed for at least the first year of life. Many women will continue into the second and third year as well.

Physicians should ascertain if the woman is nursing and not just assume that she is not based on the age of the child. If the mother is unable to answer the question, this information should be elicited from a knowledgeable family member.

**Maternal medications and breastfeeding.** Too often physicians are afraid to prescribe any medication to a nursing mother due to fear of consequences to the infant. While it certainly is important to weigh the risks and benefits of medication prescribed to any patient, there is no medical need for lactating women to suffer needlessly. With the exception of chemotherapy, there generally is at least one appropriate medication for a given condition that would permit continuation of breastfeeding. While many medications do pass into the breastmilk, only few have been found to be harmful to the infant. In fact, most medications are felt to be compatible with breastfeeding by the American Academy of Pediatrics.<sup>2,3</sup> There is no reason for a lactating mother to endure postoperative pain when analgesics are available, or feel that she needs to wean a child to take such medication. Acet-

aminophen, codeine, ibuprofen, and morphine are all considered compatible with breastfeeding. Most antibiotics are compatible as well, especially older and better known drugs. An easily accessible list is published by the American Academy of Pediatrics and should be kept handy by all physicians who treat women.<sup>3</sup> A short version is included in the Table.

**Maternal infections and breastfeeding.** Most maternal infections are not a contraindication to breastfeeding. If a mother has a minor viral illness, the baby is exposed to the mother regardless of the feeding method. By continuing to breastfeed the infant, the mother is conferring passive immunization to the infant as well. Infants born to mothers with hepatitis B infection should be given hepatitis vaccine and hepatitis immune globulin and allowed to nurse. Not only has no increase in hepatitis B been seen in breastfed babies in countries with endemic hepatitis B, but the combination of vaccine and immune globulin reduces any theoretical risk.<sup>5</sup>

Herpes infection is only a problem if the lesion is on the breast. Mothers with "cold sores" should be cautioned not to touch the lesion and then the baby, regardless of feeding method.<sup>3</sup> Mothers who have been diagnosed with syphilis but have no open lesions can resume breastfeeding after maternal antibiotic therapy. If there are lesions around the breast and nipple,



**Table. Partial list of drugs usually compatible with breastfeeding.**

Type	Generic Name
Analgesics	Acetaminophen
	Codeine
	Morphine
Anticoagulants	Heparin
	Warfarin
Anticonvulsant	Carbamazepine
	Magnesium sulfate
	Phenytoin
	Valproic acid
Antihistamines	Triprolidine
Antibiotics	Penicillin
	Amoxicillin
	Ceftriaxone
	Clindamycin
	Erythromycin
Antihypertensives	Propranolol
	Captopril
	Diltiazem
	Hydralazine
Cardiovascular	Digoxin
Decongestants	Pseudoephedrine
Gastrointestinal	Cimetidine
	Loperimide
Steroids	Prednisone
	Prednisolone
Miscellaneous	Theophylline

nursing can resume when the treatment is complete and the lesions are clear. Similarly, women diagnosed with Lyme disease should be allowed to nurse after they have begun therapy.<sup>1</sup> Mothers with active tuberculosis need to be separated from their infant until they have been on treatment for one week regardless of feeding method. The mother should be taught how to pump to maintain lactation and then allowed to breastfeed after that period with the baby receiving isoniazid.<sup>1</sup> The most common anti-tubercular drugs are compatible with breastfeeding. Mothers with positive PPDs who are recommended to be treated with isoniazid do not have to cease breastfeeding to take this

treatment.<sup>3</sup>

Maternal varicella in the perinatal period would necessitate a temporary separation of mother and baby.<sup>1</sup> The one viral illness that is a permanent contraindication to breastfeeding in the United States is HIV.<sup>4</sup>

#### **Other maternal conditions.**

Maternal asthma is not a contraindication to breastfeeding. Asthma medication for the mother is compatible with nursing and even short courses of oral steroids should not be a cause for concern. Most maternal medical conditions such as thyroid disorders, seizure disorders, diabetes, and depression are not contraindications to breastfeeding. Many women with these conditions can successfully breastfeed with careful medical

management by their physician in consultation with a professional with breastfeeding expertise. Free information is available to physicians from a computer data bank of over 14,000 articles maintained by the Lactation Study Center at the University of Rochester Medical Center (716/275-0088).

**Maternal surgery.** With proper planning, elective surgery should not require the mother to wean. As long as she is given the opportunity to pump while separated from the infant, she will be able to maintain her milk supply. If postoperative analgesics make her drowsy and unlikely to remember to pump, pumping with assistance according to a schedule similar to the frequency of which she nurses the infant should be part of her medical orders. (If unsure, every three hours for the mother of an infant under two months, every four hours for the mother of an infant two to six months, and every six hours for the mother of an older infant are reasonable minimums.) The milk that is pumped can be sent home for the use of her infant. However, the focus is to maintain the stimulus for milk production rather than focus on the volume of milk produced.

Any woman undergoing surgery to the breast should be made aware of the impact of the planned procedure on breastfeeding. For lactation to function normally, milk glands, intact duct structures, and sensory innervation to the areola are needed. In general, any procedure that will move the nipple will likely sever the ducts and preclude later breastfeeding. Removal of "lumps" generally will leave enough milk-producing tissue to enable future breastfeeding, although the volume from that breast may be slightly less. Any time there is surgical manipulation of the breast, there may be residual loss of sensation for several months but this is rarely permanent. In the absence of

sensorial stimulation for milk let down, it can be stimulated artificially with the use of oxytocin nasal spray.

**When temporary cessation is needed.** If a mother does have a condition that is not compatible with breastfeeding the first question is for how long such an interruption is needed. Lactation can be effectively maintained by pumping. The mother should be presented with this information and allowed to decide if that is too long for her.

There are many options available for maintaining a milk supply in the absence of the nursing infant. The "always accessible" option is manual (hand) expression. The advantage is that external equipment is not needed. The disadvantage is that it is physically difficult to do this multiple times per day for a number of days. Manual pumps are readily available and relatively inexpensive. Manual pumping is somewhat easier than hand expression of large volumes of milk but also can be tiring. If a prolonged temporary cessation is needed, an electrical pump can be rented. If unfamiliar with pumping, the mother can be referred for outside help such as

professional lactation consultants or the lay assistance of La Leche League (908/233-0857 and 609/261-9345).

**When permanent cessation is needed.** In the rare situations that permanent cessation is needed for medical indications, weaning should be a gradual process. Abrupt cessation of nursing is painful for the mother and can lead to engorgement, fever, and mastitis. As involuntary weaning is an unhappy situation for a nursing mother, she should be given appropriate sympathy and support. Reassurance that the infant will receive adequate nutrition from artificial feeding is important but is not the only issue to be addressed.

**How to safely wean.** To wean, the mother should be told to decrease by one feeding every two days. If the reason for weaning precludes the current use of the breastmilk, she should pump the remaining feedings and discard the milk.

## SUMMARY

Physicians of many specialties will interact with lactating mothers during their years of medical practice and should be able to support this optimal

method of infant feeding. Most medications and conditions are compatible with continued lactation. Lactating mothers can best be helped by receiving accurate medical information regarding the impact of their condition on breastfeeding and by referral to support services. ■

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1. Lawrence RA: *Breastfeeding: A Guide for the Medical Profession*. St. Louis, MO, Mosby, 1994.
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3. Briggs GG, Freeman RK, Yaffe SJ: *Drugs in Pregnancy and Lactation*. Baltimore, MD, Williams & Wilkins, 1994.
4. 1994 *Redbook: Report of the Committee on Infectious Diseases*. American Academy of Pediatrics, Elk Grove Village, 1994.

Dr. Zimmerman is an assistant professor of clinical pediatrics, UMDNJ-Robert Wood Johnson Medical School, New Brunswick. The paper was submitted in August 1995 and accepted in September 1995. Address reprint requests to Dr. Zimmerman, UMDNJ-Robert Wood Johnson Medical School, One Robert Wood Johnson Place, CN 19, New Brunswick, NJ 08903-0019.



# Part 8:

## Memoirs and musings of a medic

Stanton H. Sykes, MD

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*A retired New Jersey family physician looks back on his years in practice, commenting in rhyme, on the changes he has seen and recalling some of his memorable patients and friends. He reminisces about his decision to retire.*

---

Three decades working, still going strong;  
So many changes, though—a throng  
Of new doctors on the staff—  
And the old guard's cut in half.  
Many of my colleagues, friends,  
Have slowed, retired, or met their ends.  
The implication of the math.

The time for change is drawing near.  
We've lost docs Bob, Ralph, and Hank;  
John's retired, and death claimed Frank—  
Well, I'll consider change—next year.

Meanwhile, I'm asked, more and more,  
To retirement roasts; before  
I get to mine, I'll learn the ropes—  
The M.C. ribs you, roasts you, pokes  
Fun at you, tells many jokes;  
Then, shifting gears, he says he hopes

You'll have more years—at least a score,  
To travel, golf, or stroll the shore;  
Then a parade to podium,  
Of colleagues who spread odium,  
Then, at the end, choke up, implore

“Pal, come back to see us, often”;  
At this change of tone, you soften  
Just a bit, despite the jibes;  
You leave with mostly pleasant vibes.  
Then, in the restroom, midst the coughin',

Flushes, farts, you may hear this,  
As in a private stall you piss:  
“The old bastard's looking bad.”  
“I hope my story made him mad!”  
“There's a guy I sure won't miss!”

Or, taking your sequestered pee,  
Is this the way it's going to be—  
Will you hear, as you eavesdrop,  
“He's just really at the top

Of his form,” or “What a waste!”  
Or “He's a guy with real great taste!”  
“A gem!” “Great guy!” “Was good to me!”

Of these two scripts, which might I face,  
As I stand in that cramped space,  
Waiting for a stream that's slow?  
I guess I'll never get to know.  
I won't hear praise or be annoyed  
By calumny—I just won't void!  
I'll leave the evening's bash posthaste

And hurry to my parking spot,  
Hoping to get off the lot  
Without an action that offends.  
I know! I'll simply wear Depends™  
Then I will not care a jot!

Enough for crazy reverie!  
Back to harsh reality,  
And pressing plans that must be made  
To somehow comfort, cheer, and aid  
A nurse-friend that I've known for ages;  
I've learned she's in the latter stages  
Of cancer—hopeless, I'm afraid.

I worked for years with Ann, RN.  
She was only 40 when  
She lost her husband; having three  
Young daughters around puberty  
(Exactly 15, 12, and 10)

Was great responsibility,  
But she vowed that she would see  
Them educated and well-started.  
She could be thought of as soft-hearted—  
But hard-headed, also, seemed to me.

She was called opinionated,  
And domineering, traits that grated  
On some, but were amply balanced

By high standards, social talents,  
That, in the main, ingratiated.

In private duty, public health,  
She found employment—not great wealth,  
But wherewithal to meet her goal;  
And never was she on the dole.  
Then she really found herself

As a nurse in industry,  
Where she worked for years with me.  
She established good rapport  
With common people—knew the score  
On all rungs of society.  
Then came her retirement day,  
And, of course, I had my say  
About her life and times and work,  
Eccentricity and quirk.  
I've now another role to play;  
I'll send this little rhyme her way—  
A moment's mirth in her long stay:

What situation could be worse  
Than the illness of a nurse?  
She's been around and knows the score,  
Knows all that transpires on the floor—  
"The Nurse as Patient" is my verse:

She knows when someone slights her bath;  
Ten-second back rubs draw her wrath;  
She knows it when a pill is wrong,  
Or when someone takes too long  
To check her dressing or her cath.

Yes, ailing nurses know too much;  
They sense an inexperienced touch;  
They know the side effects of drugs;  
They know when IV tubing plugs;  
They see through sham, BS, and such.

Indeed, it's hard to change your role,  
To have to bare your heart and soul  
To strangers. Other things go bare  
Because of gowns you're forced to wear;  
Your dignity soon pays the toll!

If it's any conciliation,  
I've also faced this situation.  
I've been to operating suite;  
I've exposed my buns and feet—  
It's known as patient degradation.

Take heart from this meager crumb:  
Better days will surely come!  
We wait to hear of your release,  
When all indignities will cease,  
When joyous mood replaces glum.

Meanwhile, if docs get overbearing,  
Or your nurse seems less than caring,  
Turn your head and tune them out,  
Or, turn your back and moon them out—  
You, likewise, can be overb(e)aring!

Further sign of change ahead—  
Peg, my mainstay, came and said  
That she's decided to retire.  
I can't imagine trying to hire  
Another person, at this stage;  
And Beth is of a mind and age  
To resign her practice post—

Beth's been our lab tech, has done most  
Of the book work, taxes, such  
(The paperwork is just too much!)  
So their decisions will speed mine.  
But, first I must plan and design  
Some tribute to these loyal assistants,  
Who served with hard work and persistence.

The office without Peg will be  
Apt to face calamity.  
Who will do the monthly billing,  
Who'll screen the calls for script refilling?  
Sometimes she did the work of three!

Loyal girl Friday, 20 years—  
Need I harbor any fears  
That this term is chauvinistic,  
That feminists would go ballistic  
If it fell upon their ears?

I apply it in most loving mode  
To a woman who is owed  
Heartfelt thanks for all her service  
To me. Peggie won't be nervous  
Or upset to get this label;  
It signifies that she is able  
In front office and in rear.  
She'd spot the peaked one and steer  
Him or her to prone position.  
She knew the physical condition  
Of the waiting room and lab;  
Reminded some to pay their tab;  
And took care that idle gab  
Did not spark speculation, fears.  
So, before she can depart,  
We'll try to tell her, from the heart,  
Of our appreciation, thanks,  
By inviting, from the ranks  
Of her coworkers, family, friends,  
Representatives, to spend  
An evening, saying, "Bon voyage!"  
Of course, I'll give her a corsage,  
And try to find a little time  
To write her a retirement rhyme.

Peggy:  
Before you flee the phone and file  
Let us pause a little while  
And think about those office years—  
The smiles, the trials, the laughs, the tears;  
The memories make quite a pile.

We saw some patients age and die;  
Some moved out—we said goodbye.



We tried to give them more than pills  
To ease their pain and cure their ills—  
We let them talk, we let them cry.

You scheduled Jims and Johns and Kates,  
Trying to reduce their waits.  
Some there were whose calls you dreaded  
Because they griped or were hard-headed.  
(Such a one was Mrs. Bates.)

But mostly you preserved your cool,  
Shrugged off the rude, the crude, the fool,  
Renewed the Xanax®, Cipro, Bentyl,  
With manner kind, demeanor gentle—  
You acted by the golden rule.

So, now, forget the Medicare;  
You'll have no more Blue Cross to bear.  
Forget the damned appointment book!  
No longer will you have to look  
At skinny leg, fat derriere.

You needn't be at work by eight;  
If phone bell rings just let it wait.  
We hope you'll set a slower pace  
And not have any forms to face  
We hope you'll find retirement great!

But don't just sit and stare and mope  
When you hang up your stethoscope.  
Don't loll around and sigh and dally—  
Get out and see the Lehigh Valley!  
It's better than a TV soap!

The first week that you're gone, I'll bet  
I'll lose a chart or I'll forget  
To see someone. Your expertise  
In handling patients like Louise  
Will be a loss I'll sure regret.

I'll bet I'll phone one day and pose  
A problem while you try to doze.  
I may ask for a Blue Shield number  
Or, maybe, something even dumber,  
Help for a code stuck in my nose.

You'll no more have to stick a vein—  
A job that sometimes gave you pain.  
If boredom makes you climb the wall  
You can stick a voodoo doll.  
This often helps to clear the brain.

If fond memories make you yearn  
For your old job, please don't return.  
I have a cure for your nostalgia—  
More calls from Dean about neuralgia!  
Your homesickness won't soon return!

I now must stop this inane rhyming.  
My poem's length I see you're timing.  
The main thing is we think you're swell,  
We love you and we wish you well—  
Thus are all our voices chiming.  
Good luck!

Thus dear Peg got her salute;  
Next, I thought these lines would suit  
To tell Beth of my gratitude,  
With love, not too much platitude.

### ODE (OWED) TO BETH

Years ago she cast her lot  
With me—before I had a pot—  
Didn't have a pot to piss in  
Neither did I then have this 'un.'  
With her, I'll tell you what I got.

I got the pot at rainbow's end!  
She's one on whom you can depend:  
A gal with class and many talents  
Whose common sense keeps me in balance  
As life's littered paths I wend.

If she'd picked a midwest farmer,  
She'd have had a life much calmer.  
Not knowing that a GP's wife  
Daily faces storm and strife,  
Initially it didn't alarm her.

She's now aware this life is hectic,  
That doctors' wives become dyspeptic.  
Some give up, throw in the towel,  
Some develop nervous bowel,  
Some get symptoms anorexic.

This prairie girl came to the East,  
Where life is fast and man is beast.  
Giving up tall corn, big sky,  
She joined this traveling medic guy.  
She got to see the world, at least.

She stuck it out, became more tough,  
Developed speech and manner rough,  
Like "darn it all," and "heck" and "drat"—  
Disgusting language such as that.  
She stood her ground and took no guff.

We went abroad in Army service  
To places that could make one nervous  
The one fine day I made my mind up,  
Decided finally to wind up  
A family doctor—Lord, preserve us!

The early years were quite erratic—  
We lived in cellar, then in attic.  
When we got a decent flat,  
With ample space and welcome mat,  
She became downright ecstatic!

She helped support me through the lean years,  
Then stuck with me through good and mean  
years—

Have you heard of mean year's syndrome?  
(I can't resist a pun in poem.)  
A few she even might call keen years.

Like 1956,  
When she got both thrills and kicks

From Stephie, pre- and post-gestation;  
That arrival brought elation.  
Then there was formula to fix,

Parts to powder, parts to shine.  
Beth enjoyed these chores just fine,  
Said she'd like to have another.  
Soon our daughter had a brother—  
This was 1959.

And all the while Beth did her bit  
In office work; she used her wit  
To figure payroll, keep the books—  
An office aide who also cooks!  
She may have tired, but never quit.

She mastered FICA forms and taxes,  
Calculators, Xerox, faxes.  
Lab tech, file clerk, nurse, and wife—  
She even had some social life—  
Hooks a rug while she relaxes.

Now she thinks that she's retiring,  
But to the West our son is siring  
Grandchild number one, and counting.  
So now the evidence is mounting  
A babysitter they're requiring.

Looks like poor Beth's work's not done.  
She'll mind the grandkids, one by one—  
Or maybe even two by two  
If our daughter now comes through,  
Deciding to keep pace with son.

Poor Beth, you put aside your pipette  
Only to take up the layette.  
So wipe your brow, girl, hoist your girdle;  
Set sights on another hurdle.  
You haven't paid your dues, just yet!

Since my office staff has parted  
My tenure here will be half-hearted.  
I'd better promptly contemplate

My plans—if I procrastinate  
Perhaps I'll soon wind up outsmarted

By Father Time; if patients come  
And find me blind and deaf and dumb,  
Spilling specimens on my clothes,  
Or falling, often, in a doze  
My practice surely will succumb.

Nineteen eighty-nine's near done;  
I've played the game—can't say I've won,  
But perhaps I've tied the score;  
No, I won't play one year more—  
Too much a chore, no longer fun.

Nineteen ninety; I had spent  
Years enough, though where they went  
Is a mystery, looking back;  
At any rate, 'twas time to slack  
Up a bit, so now I'd rent

The office to a new young doc;  
I'd sell the practice, with its stock  
Of patients' records—hoped goodwill  
Would provide him work; I'd still  
Keep in touch with my old flock

By doing a housecall or two;  
Twice a week I'd do a few  
Exams for local industry,  
But, largely, now I would be free  
Of rigid hours; at first I'd rue

My decision; jealousy  
Of my young rival ate at me,  
And I thought it really true  
When old folks told me, "Without you  
There's no hope—who can we see?"

But most managed the transition  
To the new staff and physician.  
Though it briefly made me ill,  
I found that a bitter pill  
Named "no one's indispensable"  
Was the cure for my condition. ■

For Parts 9 and 10, please contact the author. Dr. Sykes is affiliated with Warren Hospital, Phillipsburg. Address reprint requests to Dr. Sykes, 428 Third Street, Belvidere, NJ 07823.



**HOUSING APPLICATION  
230th ANNUAL MEETING  
MEDICAL SOCIETY OF NEW JERSEY  
APRIL 30-MAY 4, 1996**

**TRUMP TAJ MAHAL CASINO/RESORT****1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401****RESERVATIONS DEPARTMENT 1-800-825/8786***(Please Print)*

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Sharing With \_\_\_\_\_

Date of Arrival \_\_\_\_\_ Time \_\_\_\_\_

Date of Departure \_\_\_\_\_ Time \_\_\_\_\_

***A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the TRUMP TAJ MAHAL CASINO/RESORT or complete the following:***

Card # \_\_\_\_\_ Type \_\_\_\_\_ Exp. Date \_\_\_\_\_

**SCHEDULE OF RATES SUBJECT TO 12% TAX**☐ SINGLE \$110    ☐ DOUBLE \$110 ***(Reservations must be received prior to March 30, 1996.)***

Extra Person \$25

☐ One-Bedroom Suite \$275 per day☐ One-Bedroom Hospitality Suite \$350 per day

Check-out time is 12 NOON. Rooms may not be available for check-in until after 4 P.M. Check-in time on Sunday, is 6 P.M. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION IS REQUIRED FOR A FULL REFUND. PARKING: There is a state-imposed \$2 minimum charge per 24-hour period for each motor vehicle parking on the premises.

☐ Check if official delegate                      County \_\_\_\_\_

PLEASE NOTE: Current state sales tax is 3 percent and occupancy tax is 9 percent, and room usage fee is \$2 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund that will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts, and casino gaming.

**MAIL THIS APPLICATION TO: Reservations**

Trump Taj Mahal Casino/Resort  
1000 Boardwalk at Virginia Avenue  
Atlantic City, NJ 08401

# **MEDICAL SOCIETY OF NEW JERSEY 1996 ANNUAL MEETING**

*May 1 through May 4, 1996  
Trump Taj Mahal Casino/Resort  
Atlantic City, NJ*

## **DAILY SCHEDULE**

### **WEDNESDAY, MAY 1, 1996**

- 8:00 A.M. Registration Opens
- 8:30 A.M. Message Center Opens
- 9:00 A.M. AMA Delegation Meeting
- 10:00 A.M. Educational Program
- 11:30 A.M. The Academy of Medicine of New Jersey Lecture
- 12:30 P.M. Exhibits and AMA-ERF Boutique Open
- 1:30 P.M. House of Delegates
- 3:00 P.M. Reference Committees
- 7:00 P.M. Officers' Reception/Dinner

### **THURSDAY, MAY 2, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. Reference Committees
- 9:30 A.M. Exhibits Open
- 12 NOON Golden Merit Award Ceremony/Reception
- 1:30 P.M. House of Delegates (Election)
- 4:00 P.M. JEMPAC Political Forum
- 5:00 P.M. JEMPAC Wine and Cheese Reception
- 6:00 P.M. Camden County Medical Society Reception Honoring President and Mrs. Louis L. Keeler

### **FRIDAY, MAY 3, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. House of Delegates
- 9:30 A.M. Exhibits Open
- 12:30 P.M. Luncheon Meeting—Members of the Hospital Medical Staff Section
- 1:00 P.M. Exhibits Close
- 7:00 P.M. Inaugural Reception
- 8:00 P.M. Inaugural Dinner Honoring Anthony P. Caggiano, Jr, MD

### **SATURDAY, MAY 4, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. HIV Educational Program



# DOCTORS' NOTEBOOK

## TRUSTEES MINUTES

A meeting of the Medical Society of New Jersey (MSNJ) Board of Trustees was held on December 17, 1995, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

**BME vice-president.** Acknowledged the election of Bernard Robins, MD, as the vice-president of the state Board of Medical Examiners (BME).

### Report of executive director.

**1. Funding for charity care.** Noted that MSNJ strongly favors an increase in the cigarette tax and has been lobbying the Whitman administration to endorse such a tax hike.

**2. Pennsylvania Hospital Insurance Company (PHICO).** Heard that PHICO, a carrier controlled by the Pennsylvania Hospital Association, is soliciting professional liability business in

New Jersey and noted that physicians should consult current insurance carriers for a comparison of policies and services before changing carriers.

**3. Endorsed membership benefit programs.** Acknowledged that the Committee on Membership Services was dissolved and endorsed membership benefit programs were transferred to the Medical Inter-Insurance Exchange Financial Services.

**Council on Medical Services.** Approved the following: That MSNJ suggest that the Patient Protection Act be amended to include, when services are denied for medical reasons, that the reason be specified at the time of the initial communication.

**Council on Public Health.** Endorsed the following: Resolved, that MSNJ commends the Food and Drug Administration (FDA) for publicly sharing its view that the agency does have authority to

regulate tobacco products; and be it further, Resolved, that MSNJ urge the New Jersey Congressional Delegation to clearly mandate the FDA to develop an appropriate, comprehensive, and regulatory apparatus for tobacco products, and to appropriate adequate funds for this function.

**Committee on Biomedical Ethics.** Approved the following three recommendations:

1. That the Board of Trustees approve the out-of-hospital DNR orders policy as a policy written and approved by MSNJ to provide assistance to physicians and emergency medical personnel when determining whether to withhold or withdraw life-sustaining treatment from patients in an out-of-hospital setting.

2. That the Board of Trustees forward a communication to Commissioner Len Fishman to obtain the endorsement of the New Jersey State Department of Health.

3. That the out-of-hospital orders policy be printed in *NEW JERSEY MEDICINE* as a means of educating the membership and other health care professionals.

**Strategic Planning Task Force.** Approved the following: That MSNJ send a letter to the county medical societies describing the new computer system and dues billing and collection capabilities, and offering to any county to have their billing taken over by MSNJ, on a strictly voluntary basis.

**AMA Interim Meeting.** Heard from Irving P. Ratner, MD, chair, New Jersey delegation, on the following topics from the AMA Interim Meeting: study of the Federation; JCAHO manual; single conversion factor; HMO contracts; National Committee for

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Please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

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Quality Assurance; folic acid; and practice parameters. In addition, heard that New Jersey submitted four resolutions [AMA billing was referred to AMA Board of Trustees; all-integer CPT coding proposal was defeated; reaffirmed existing policy concerning Milliman and Robertson guidelines; and drug prescription plans resolution was withdrawn by the sponsor]. And, noted the delegation's strong support for Palma E.

Formica, MD, for re-election to the AMA Board of Trustees and for Joseph N. Micale, MD, for election to the Council on Medical Education, and for Robert J. Weierman, MD, as a candidate for chair of the Organized Medical Staff Section.

**Reports.** Received reports from MSNJ President Louis L. Keeler, MD; Paul F. Larson, MD, for UMDNJ; Gary S. Carter, for the

New Jersey Hospital Association; Henry D. Rosin, MD, for the Physician Healthcare Plan of New Jersey, Inc.; Ravi D. Goel, for the MSNJ Student Association; Christine Kline, for the Medical Alliance to MSNJ; Alan J. Lippman, MD, for The Academy of Medicine of New Jersey; and JaNoel Bess, for NEW JERSEY BREATHEs.

## UMDNJ NOTES

**UMDNJ Board of Trustees.** Isabel Miranda, vice-president and director of trusts and estates for Citibank, in New York City, has been appointed by Governor Whitman to the Board of Trustees of the University of Medicine and Dentistry of New Jersey (UMDNJ). Ms. Miranda has been a fiduciary officer specializing in trusts and estate planning at Citibank since 1986. Prior to that, she held management positions in estate and trust administration at Irving Trust Company and Marine Midland Bank.

**Dr. Paz named dean.** Dr. Harold L. Paz, a noted medical educator and administrator, has been named dean of UMDNJ-Robert Wood Johnson Medical

School. He had been acting dean since April 1995. Dr. Paz also is chief executive officer and medical director of the University Medical Group, the multispecialty group practice of the medical school.

**UMDNJ and The New York Hospital form alliance.** UMDNJ and The New York Hospital have formed the first partnership nationwide between two academically based health care systems from two states. This new partnership represents a network of more than 14,000 practitioners. The two systems are University HealthCare Corporation, a statewide subsidiary of UMDNJ, and The New York Hospital Care Network, Inc., a subsidiary of

The Society of New York Hospital, Inc.

The New York Hospital Care Network, Inc., is the managed care network of The New York Hospital, the primary teaching affiliate of Cornell University Medical College. The University HealthCare Corporation is a not-for-profit subsidiary of UMDNJ governed by a separate Board of Trustees.

**Full-service children's hospital.** A multimillion-dollar construction project will transform the Children's Center of Robert Wood Johnson University Hospital, New Brunswick, into the first full-service Children's Hospital in central New Jersey.

Children's Hospital at Robert Wood Johnson University Hospital is a partnership between the pediatric departments of the hospital and UMDNJ-Robert Wood Johnson Medical School.

A three-story addition, featuring a pediatric emergency room and a separate entrance, is scheduled to be built onto the pediatric wing starting in 1996. Over five years, Children's Hospital plans to add three pediatric operating rooms, a pediatric same-day surgery suite, pediatric radiology equipment, pediatric physical therapy and rehabilitation rooms, and a classroom for tutoring.

Dr. David Carver, of the Department of Pediatrics at the medical school, is physician-in-chief of Children's Hospital. □ Stanley S. Bergen, Jr, MD

# 1996 MSNJ Board of Trustees Meeting Schedule

**February 18, 1996**

**March 17, 1996**

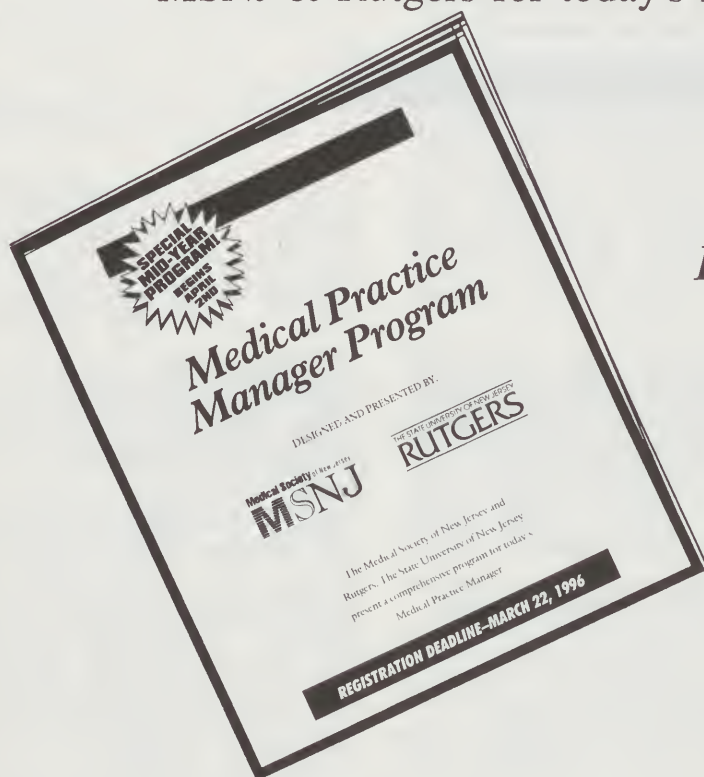
**April 14, 1996**



# ANNOUNCING

## The Medical Practice Manager Program

A Comprehensive Program developed by  
MSNJ & Rutgers for today's Medical Practice Manager



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For more information, please contact Julie Jadlocki 609/896-1766 ext 209

In light of unprecedented changes in health care administration coupled with a technological explosion in management, Rutgers University and the Medical Society of New Jersey (MSNJ) have cofounded the Medical Practice Manager (MPM) program. The program focuses on teaching management skills to medical practice managers, assisting them to survive in the 90s and into the 21st century. The MPM curriculum was designed to address the technical, medical, and management concepts in a step-by-step approach.

Offered as the equivalent of three undergraduate college courses, the program is designed to educate full-time medical office professionals in computer usage and applications, management techniques, and the medical environment. Students registering for the program can be eligible for nine graduate level credits towards a master's degree in public administration.

The program is divided into three areas: computers and medical technology; management issues and strategies; and the medical environment. Classes meet three days a month over an eight-month period. This scheduling format was developed to minimize out-of-office time, while giving the student sufficient time between classes to absorb the new concepts.

The current MPM program, which began in October 1995, is receiving rave reviews from students and administrators (Figure). "We've heard numerous reports from the students. They've applied classroom examples to increase office automation," said George McDonough, the program's director and a professor of public administration at Rutgers. "After the first three computer classes, I noted a dramatic change in students' understanding and attitudes toward this technology. They're learning, having fun, and

most importantly, bringing computer skills back to the office."

"I'm already applying spreadsheet concepts learned in class to our payroll increases and budget projections for next year," stated Tracy DeVito, a medical practice manager from Bergen County.

In January, the program shifted into its second course on management issues and strategies. This course focused on personnel issues and practices. Students used case studies to explore issues such as employee selection and evalua-

ment where learning is exciting and fun."

After the students complete the management course, they will begin the third section of the program on the medical environment. Students study the myriad of new regulations and office safety and compliance requirements. A major focus for this course is health insurance issues, including coding for patient care and reimbursement. In addition, billing and payment issues will be analyzed in conjunction with



**Figure.** Students in the first Medical Practice Manager program study computer applications. © David Schild

tion, effective communication, customer/patient service, market assessment/positioning a medical practice, and managing in a complex environment. Each of these topics was analyzed through lectures, readings, and classroom discussion.

"We encourage input and challenges from our students," says Mr. McDonough.

"We have created a curriculum for medical managers that lends itself to the dynamics of classroom discussion. In short, the boredom associated with the traditional lecturer/listener relationship is minimized in a participatory environ-

ment where learning is exciting and fun." The remainder of this course will include discussions of quality of care and educational and laboratory issues.

The MPM program is being offered at a time when changes in regulations and technological growth are problems facing the medical community.

MSNJ and Rutgers will launch the second annual Medical Practice Managers Program in April 1996. Programs will run concurrently in both the northern and central regions of the state. For more information on the program, call 609/896-1766.



# EDITORIAL CRITERIA

## CONTENT

*NEW JERSEY MEDICINE* is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and

special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey

and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE*."

## SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings,

and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated

parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*:

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

## PUBLICATION POLICY

Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved

for the editor. No direct contact between the reviewers and the authors will be permitted.

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You are invited to participate. Any medical staff of a hospital, integrated delivery system, or health care plan may designate an OMSS representative, who must be an AMA member with active medical privileges.

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# CONTINUING EDUCATION

## MEDICINE

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (in italics) for further information.

### February

- 21 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 22 **Visiting Professor Lecture**  
St. Barnabas Medical Center,  
Livingston (*AMNJ*)
- 28 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 28 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 29 **Infection Control in the HIV Era**  
Union Hospital, Union (*AMNJ*)

### March

- 4 **Pathophysiological Roles of Nitric Oxide and Peroxynitrite**  
UMDNJ-School of Osteopathic Medicine, Stratford (*UMDNJ*)
- 6 **Principles of Dermatological Therapy**  
The General Hospital Center at Passaic, Passaic (*AMNJ*)
- 6 **Multimodality Imaging of Ovarian Carcinoma**  
Cooper Hospital, Camden (*AMNJ*)
- 6 **Multidrug Resistance in Neoplasia**  
Corning Clinical Laboratories, Teterboro (*AMNJ*)
- 6 **Interhospital Endocrine Rounds**  
University Hospital, Newark (*AMNJ*)
- 6 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 6 **Minimizing Liability under Managed Care**  
*MIIX*, Lawrenceville (*MIIX and UMDNJ*)
- 8 **Minimizing Liability under Managed Care**  
UMDNJ-Robert Wood Johnson

- Medical School, New Brunswick (*MIIX and UMDNJ*)
- 9- **8th Annual Review Course in**
- 17 **Physical Medicine and Rehabilitation**  
Ramada Hotel, East Hanover  
(*Kessler Institute*)
- 12 **Monthly Dermatology Meeting**  
Schering Corporation,  
Kenilworth (*Dermatological Society of NJ*)
- 13 **Occupational Asthma in New Jersey**  
St. Mary's Hospital, Passaic  
(*AMNJ*)
- 13 **Radiation Oncology Section Meeting**  
The Manor, West Orange  
(*AMNJ*)
- 13 **Vascular Society of New Jersey Annual Meeting**  
Englewood Hospital and Medical Center, Englewood  
(*AMNJ*)
- 13 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 13 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 16- **37th Annual NJ Postgraduate**
- 17 **Anesthesia Seminar**  
Trump Plaza Hotel & Casino,  
Atlantic City (*AMNJ*)
- 18 **Role of CGMP in Visual Signal Transduction**

- UMDNJ-School of Osteopathic Medicine, Stratford (*UMDNJ*)
- 20 **Family Medicine Series**  
UMDNJ-Robert Wood Johnson Medical School, Camden  
(*Cooper Hospital*)
- 20 **Thriving in a Competitive Environment: Strategies for Success**  
MSNJ Executive Offices,  
Lawrenceville (*AMNJ*)
- 20 **Collagen Disease Update**  
St. Mary's Hospital, Passaic  
(*AMNJ*)
- 20 **Prevention of Lower Extremity Amputation**  
The General Hospital Center at Passaic, Passaic (*AMNJ*)
- 20 **13th Annual Symposium on Facial Plastic Surgery**  
Garden State Arts Center,  
Holmdel (*AMNJ*)
- 20 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 20 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 21 **Diagnostic Radiology Section Meeting**  
St. Barnabas Medical Center,  
Livingston (*AMNJ*)
- 27 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 27 **Medical Grand Rounds**

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## **Bayshore Community Hospital**

Holmdel, NJ

**Continuing Medical Education  
Lecture Series  
12 noon-1 pm**

Date: February 16, 1996

Topic: *"Urinary Incontinence"*

Speaker: B. Surya, MD

Date: February 23, 1996

Topic: *"Update on Asthma Management"*

Speaker: Donald Pearlman, MD

Date: March 1, 1996

Topic: *"Slowing the Progression of  
Coronary Disease: The value of  
Cholesterol Management"*

Speaker: Robert T. Faillace, MD

Date: March 8, 1996

Topic: *"Mood Disorders in Women"*

Speaker: Sylvia Templeton, MD

Date: March 15, 1996

Topic: *"Prophylaxis and Coagulation of  
Atrial Fibrillation"*

Speaker: Michael Ezekowitz, MD

Date: March 22, 1996

Topic: To be announced

Speaker: To be announced

Date: March 29, 1996

Topic: *"Management of the Chronic Pain Patient"*

Speaker: David Handlin, MD

**For more information call**

**908-888-7377**

## **IX Annual International Conference On Lyme Borreliosis**

### **Chronic Lyme Borreliosis: Basic Science and Clinical Approches**

With a Panel on Emerging Tick-borne Diseases

Boston, Massachusetts

April 19 & 20, 1996

CME Category 1 Accreditation

**Conference Chair:**

Martina Ziska, M.D. Lyme Disease Foundation, Hartford, CT

**Conference Co-Chairs**

Sam T. Donta, M.D. Boston University Hospital, Boston, MA

Elisabeth Aberer, M.D. University of Graz, Austria

**Poster Session Chair:**

Jonathan A. Edlow, M.D. Mount Auburn Hospital, Cambridge, MA

For Registration Information Contact:

The Lyme Disease Foundation, Inc.

One Financial Plaza

Hartford, CT 06103

Phone: (860) 525-2000

Fax: (860) 525-8425

E-Mail: [lymefnd@aol.com](mailto:lymefnd@aol.com)





- VA Medical Center,  
East Orange (AMNJ)
- 28 **Visiting Professor Lecture**  
St. Barnabas Medical Center,  
Livingston (AMNJ)
- 29 **Neuropsychiatric and  
Psychosocial Aspects of  
HIV/AIDS**  
Union Hospital, Union (AMNJ)
- 29- **Semmelweis-Waters Ob/Gyn**  
31 **Conference**  
Bally's Park Place, Atlantic City  
(UMDNJ)
- April**
- 3 **Treatment of Epstein-Barr  
Virus and Cytomegalovirus**  
The General Hospital Center at  
Passaic, Passaic (AMNJ)
- 3 **Overview of Cervical  
Neoplasia**  
Corning Clinical Laboratories,  
Teterboro (AMNJ)
- 3 **Present State of Snoring and  
Sleep Apnea**  
St. Mary's Hospital, Passaic  
(AMNJ)
- 3 **Interhospital Endocrine  
Rounds**  
University Hospital, Newark  
(AMNJ)
- 3 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (AMNJ)
- 8 **Monthly Dermatology  
Meeting**  
Schering Corporation,  
Kenilworth (*Dermatological  
Society of NJ*)
- 10 **Psychiatry: Medication  
Interactions**  
St. Mary's Hospital, Passaic  
(AMNJ)
- 10 **Interhospital Endocrine  
Rounds**
- University Hospital, Newark  
(AMNJ)
- 10 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (AMNJ)
- 11 **Scientific Meeting: Head and  
Neck Oncology Section**  
The Manor, West Orange  
(AMNJ)
- 12 **Isoprostanes and Oxidant  
Stress**  
UMDNJ-School of Osteopathic  
Medicine, Stratford (UMDNJ)
- 16- **Annual Spring Meeting: NJ**  
21 **Orthopaedic Society**  
Four Seasons Resort, Nevis,  
West Indies (AMNJ)
- 17 **Making Decisions in  
Transfusion Medicine**  
The General Hospital Center at  
Passaic, Passaic (AMNJ)
- 17 **Thriving in a Competitive  
Environment: Strategies for  
Success**  
MSNJ Executive Offices,  
Lawrenceville (AMNJ)
- 17 **Magnetic Resonance Imaging  
of the Nondegenerative  
Disease of the Spine**  
Cooper Hospital, Camden  
(AMNJ)
- 17 **Estrogen Replacement  
Therapy and Management of  
Menopause**  
St. Mary's Hospital, Passaic  
(AMNJ)
- 17 **Family Medicine Series**  
UMDNJ-Robert Wood Johnson  
Medical School, Camden  
(Cooper Hospital)
- 17 **Interhospital Endocrine  
Rounds**  
University Hospital, Newark  
(AMNJ)
- 17 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (AMNJ)
- 18 **Diagnostic Radiology Section  
and NJ Institute of Ultrasound  
in Medicine Meeting**  
St. Barnabas Medical Center,  
Livingston (AMNJ)
- 18- **Practical Primary Care of**  
19 **Female Patients**  
Ocean Place Hilton, Long  
Branch (UMDNJ)
- 23 **Radiological Society of New  
Jersey Annual Meeting**  
Hyatt Regency, New  
Brunswick (AMNJ)
- 24 **23rd Annual Pacemaker  
Meeting**  
Sheraton at Woodbridge Place,  
Iselin (AMNJ)
- 24 **Minimizing Liability under  
Managed Care**  
MIIX, Lawrenceville (*MIIX  
and UMDNJ*)
- 24 **30th Annual William P.  
Burpeau Award Dinner and  
Lecture**  
The Manor, West Orange  
(AMNJ)
- 24 **Interhospital Endocrine  
Rounds**  
University Hospital, Newark  
(AMNJ)
- 24 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (AMNJ)
- 25 **Visiting Professor Lecture**  
St. Barnabas Medical Center,  
Livingston (AMNJ)
- 26 **Minimizing Liability under  
Managed Care**  
UMDNJ-Robert Wood Johnson  
Medical School, New  
Brunswick (*MIIX and UMDNJ*)

# Hahnemann University Hospital

## Department of Medicine Grand Rounds Wednesdays 8:30 to 9:30 a.m.

Classroom C (Alumni Hall), 2nd Floor, New College Building, Hahnemann University, 15th & Vine Streets (15th Street Entrance), Philadelphia  
For more information, contact the Office of Continuing Education at 215-762-8263.

### MARCH 1996

MARCH 6th

#### Clinical Pathologic Conference

*Dina Capalongo, D.O.*

*Michael Downing, M.D.*

*Lawrence McDermott, M.D.*

*Lisa Scheib, M.D.*

Chief Residents, Hahnemann University Hospital

MARCH 13th

#### New Concepts in Pulmonary Medicine: Sleep

##### Apnea, Respiratory Failure

*Barry Fuchs, M.D.*

Assistant Professor of Medicine

Medical College of Pennsylvania and Hahnemann

University, Division of Pulmonary and Critical Care

Medicine, Hahnemann University Hospital

*Joanne Getsy, M.D.*

Assistant Professor of Medicine

Medical College of Pennsylvania and Hahnemann

University, Director, Sleep Lab., Division of

Pulmonary and Critical Care Medicine, Medical

College of Pennsylvania Hospital

*Edward S. Schulman, M.D.*

Professor of Medicine

Medical College of Pennsylvania and Hahnemann

University, Division of Pulmonary and Critical Care

Medicine, Hahnemann University Hospital

### MARCH 1996

MARCH 20th

#### Cutaneous Signs of Systemic Disease

*Melda Isaac, M.D.*

Assistant Professor of Dermatology

Medical College of Pennsylvania and

Hahnemann University

MARCH 27th

#### Medical Education and Medical Practice—What's Next: A View from Washington and the AMA

*Richard F. Corlin, M.D.*

Speaker of the House of Delegates

American Medical Association, Assistant Clinical

Professor of Medicine, UCLA School of Medicine,

Los Angeles, CA

### APRIL 1996

APRIL 3rd

#### The Calcium Antagonist Controversy

*Franz Messerli, M.D.*

Clinical Professor of Medicine

Tulane University School of Medicine, Director,

Hypertension Laboratory, Ochsner Clinic,

New Orleans, LA

#### Racial Differences in the Treatment of Hypertension

*Barry J. Materson, M.D.*

Professor of Medicine

University of Miami School of Medicine, Miami, FL

### APRIL 1996

APRIL 10th

#### The Thrombosis Prone Patient: Abnormalities of Protein C and Factor V

*Joan C. Hoak, M.D.*

Former Director, Division of Blood Diseases and

Resources, National Heart, Lung and Blood

Institute (NHLBI), Clinical Professor of Medicine,

Uniformed Services University of the Health

Sciences, Consultant to Walter Reed Army

Hospital, Bethesda, MD

APRIL 17th

#### Treatment of HIV and Related Opportunistic Infections

*Martin S. Hirsch, M.D.*

Professor of Medicine

Harvard Medical School, Head, Infectious Diseases

Unit, Massachusetts General Hospital, Boston, MA

APRIL 24th

#### Abnormalities of Growth Hormone

*Lawrence Frohman, M.D.*

Professor and Head Department of Medicine,

University of Illinois at Chicago School of

Medicine, Chicago, IL

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

MARCH  
No Seminar

APRIL 3, 1996  
Hypertension: Understanding the Controversies  
in the Treatment of Hypertension  
Franz Messerli, M.D., Barry J. Materson, M.D.

APRIL 17, 1996  
Treatment of HIV and Related  
Opportunistic Infections  
Martin S. Hirsch, M.D.

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

**Full Disclosure Statement:** All faculty participating in continuing medical education programs sponsored by The Medical College of Pennsylvania and Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

**Statement of Accreditation:** The Medical College of Pennsylvania and Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The Medical College of Pennsylvania and Hahnemann University designates 1.0 credit hour of Category 1 of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities.

This program is eligible for 1.0 credit hour for each hour of attendance in Category 2A of the American Osteopathic Association.



# IN MEMORIAM

## MARGARET A. CLARK

Woodcliff Lake resident Margaret Aymar Clark, MD, died on October 10, 1994, at the age of 78. Dr. Clark was born on July 23, 1916, in Woodcliff Lake, and was graduated from Columbia University College of Physicians and Surgeons, New York, in 1943. Dr. Clark received a New Jersey medical license the following

year. She completed an internship at Bellevue Hospital, New York, and Hackensack Hospital. An obstetrician and pediatrician, Dr. Clark practiced in Ridgewood and Woodcliff Lake, and was affiliated with Hackensack Hospital and Valley Hospital, Ridgewood. Dr. Clark was a member of our Bergen County component.

## SALVATORE J. DETRANO

We have received word of the death of Weehawken resident, Salvatore Joseph Detrano, MD, on June 12, 1995, at the age of 82. Dr. Detrano was born on May 20, 1913, in Long Branch and was awarded a medical degree from New York Medical College, New York, in 1941. He was a proctologist and was affiliated with

Christ Hospital, Jersey City. Dr. Detrano was a member of our Hudson County component and of the American Medical Association, and was a fellow of the American Society of Colon and Rectal Surgery. Dr. Detrano resided in Weehawken and Monroe Township.

## ROBERT B. EDELMANN

Seventy-year-old Robert Benedict Edelmann, MD, passed away on January 2, 1995. Dr. Edelmann was a surgeon. He was born on June 18, 1924, in Union City, and was graduated from Long Island College of Medicine, New York, in 1947. During his 35-year medical career, Dr. Edelmann was chief of thoracic surgery at Christ Hospital, Jersey City; consulting surgeon to the VA Hospital; a member of the teach-

ing faculty of the College of Medicine and Dentistry of New Jersey; and affiliated with St. Francis Hospital, Greenville Hospital, and Fairmount Hospital, in Jersey City. He was a member of our Hudson County component and of the American Medical Association. Dr. Edelmann served in the United States Navy during World War II and in the United States Navy Reserve Medical Corps.

## PHILIP J. MACLAREN

Bergenfield resident Philip Joseph MacLaren, MD, passed away on October 14, 1994, at the grand age of 83. Born on May 6, 1911, in New York City, Dr. MacLaren was a 1937 graduate of Hahnemann Medical College, Philadelphia. The following year, Dr. MacLaren completed an internship at Holy Name Hospital, Teaneck, and received a New Jersey medical license. During his medical career as a family

practitioner, Dr. MacLaren maintained a practice in Westwood and Tenaflly, was on the Westwood Board of Health from 1939 to 1942, and was a school physician for Tenaflly High School. He was a member of our Bergen County component and of the American Medical Association. Dr. MacLaren was a United States Navy World War II veteran.

## EUGENE H. KAIN

A 1944 graduate of Jefferson Medical College, Philadelphia, Eugene Hillegass Kain, MD, passed away on November 6, 1994. He was born on June 17, 1918, in Camden, and resided in Haddonfield. Dr. Kain practiced in Camden, was chief attending surgeon at Cooper Hospital, Camden, and was a faculty member at Jefferson Medical College. Dr. Kain was past-president of the American College of Surgeons, New Jersey Chapter,

and of the Camden County Heart Association. He also was a diplomate of the American Board of Surgeons, and a member of our Camden County component and of the American Medical Association. Dr. Kain completed an internship at Cooper Hospital and a residency at Cooper Hospital and Philadelphia VA Hospital. Dr. Kain served in the United States Army during World War II.

## FRANZ KASTLER

At the grand age of 94, Franz Kastler, MD, passed away on May 25, 1995. Born on January 29, 1901, in St. Oswald, Austria, Dr. Kastler was graduated from the University of Vienna, Austria, in 1927 and received a New Jersey medical license in 1929. Dr. Kastler was an internist with an

office in Rutherford; he also was affiliated with St. Mary's Hospital, Passaic. Dr. Kastler was a member of the American Medical Association, the American Society of Clinical Pathologists, the American Heart Association, and our Bergen County component.

## STEPHEN D. KRASNICA

We have received word of the death of Mendham resident Stephen Dennis Krasnica, MD. Dr. Krasnica was born on March 3, 1948, in Jamaica, New York, and was graduated from New York University Medical School, New York, in 1972, where he also completed a residency and internship. Dr. Krasnica was a cardiologist and internist in

private practice in Morristown. He also was a partner in Corvas Diagnostics, Inc., Morristown. Dr. Krasnica was attending at Morristown Medical Center. He was a member of our Morris County component and of the American Medical Association. Dr. Krasnica was a diplomate of the American Board of Cardiovascular Disease.

## HARRY F. SUTER

Past-president of the Salem County Medical Society, Penns Grove resident Harry Franklin Suter, MD, passed away on March 3, 1995. Dr. Suter was born on September 23, 1902, in Wilksburg, Pennsylvania, and was awarded a medical degree from Jefferson Medical College, Philadelphia, in 1931. The following year, Dr. Suter received a New Jersey medical license. He maintained a medical office in Penns Grove for many years. Dr. Suter was chief of medicine at Salem Hospital from 1953 to 1968, and the first physician to

perform electrocardiograms at the hospital. He also served on the Joint Conference Committee and the Medical Records Committee at Salem Hospital. Dr. Suter was a school physician for the Penns Grove school system, and was a member of the American Medical Association. Dr. Suter was awarded the MSNJ Golden Merit Award in 1981, and was honored as the grand marshal of the Penns Grove parade in 1994 for over 60 years of caring for the people of Penns Grove.



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1475 square feet Saddle River Road. Time share if desired. Well maintained attractive setting with both ample on site and street parking. Convenient to area hospitals and nursing home across street. Terms negotiable. Joachim Oppenheimer, MD, 201-652-0930.

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## 130 OPPORTUNITY WANTED (ALPHABETICAL BY SPECIALTY)

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## 150 LOCUM TENENS WANTED

## 160 ASSOCIATIONS & PARTNERSHIPS

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## 310 OFFICES TO SHARE

## 320 OFFICES FOR SALE

## 330 MEDICAL BUILDING FOR SALE OR LEASE

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\$ 1.00 per word

\$45.00 minimum

Confidential Box # = 5 words

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\$60.00 first 1" per column

\$30.00 each additional 1/2" per column

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**FAX—609-393-3759**

**DEADLINE**—10th of month preceding month of issue

**QUESTIONS**—Call 609-393-7196

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**BOLD HEADING (optional)**  
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**Requested Category:**

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**(35 characters per line)**

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**FAMILY PRACTITIONER—Board** Certified or Board Eligible to join a growing, established Family Practice located in Bergen County. Potential towards partnership. To start ASAP, weekdays 9-5. Call 201-722-0943.

**INTERNIST—To affiliate with two** internists in established, well-positioned practices, for Union County. Reply to Box No. 117. NEW JERSEY MEDICINE.

**ORTHOPEDIC SURGEON—Board** Certified needed. Prefer private solo practitioner in his 50's who may wish to slow down by performing once weekly Independent Medical (orthopedic defense) exams in Union, Essex or north New Jersey area. Excellent remuneration. Send CV to Box No. 121, NEW JERSEY MEDICINE.

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**Classified Advertisement Revisions  
Effective April 1996 Issue—See pages 124 & 125**

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110 & 111**

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# NEW JERSEY MEDICINE

March 1996

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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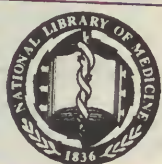
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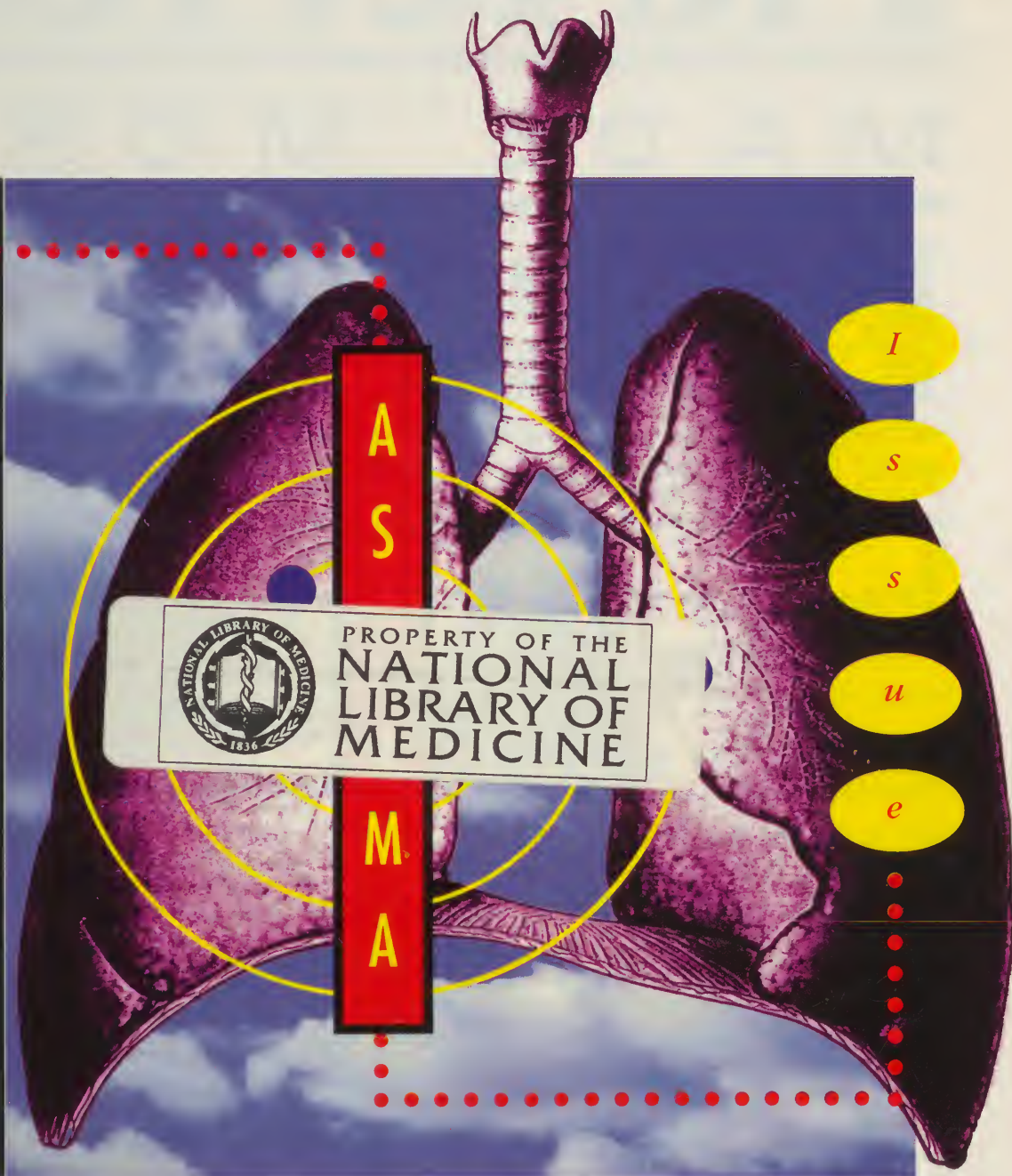
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# NewsWatch

## **MSNJ SEEKS TIMELY CDS RENEWALS . . .**

In a letter to state Board of Medical Examiners (BME) President Robert L. Johnson, MD, the Medical Society of New Jersey (MSNJ) has requested administrative action to improve the processing of controlled and dangerous substances registration renewals.

Authored by MSNJ Secretary George J. Hill, MD, the letter notes a pattern of excessive delays and a one-time technical problem involving the presence of a CDS renewal form on the reverse side of a license renewal form.

## **. . . AND ACTION ON HMOs . . .**

In other action before BME, new controls on managed care were advocated by MSNJ. During a three-part BME series of conferences on managed care, MSNJ Past-President Fred M. Palace, MD, called for three measures: a regulation prohibiting so-called "gag clauses" in HMO-provider contracts that deter physicians from discussing diagnostic and treatment options with patients; a regulation prohibiting clauses in provider contracts that deter physicians from bringing appeals against the HMO; and establishment of a procedure for reviewing actions against out-of-state medical directors of HMOs.

One HMO accused of including gag clauses in contracts, US Healthcare, has announced that it is discontinuing the practice. The announcement follows extensive adverse publicity, much of which was generated by MSNJ.

For a copy of Dr. Palace's statement, which was developed in conjunction with MSNJ President Louis L. Keeler, MD, contact Karen Monsees at MSNJ, telephone 609/896-1766, extension 245.

## **STATE DEPARTMENT MERGER PROPOSED . . .**

Governor Whitman startled much of the state's health and human services communities by proposing, as part of her fiscal year 1997 budget message, the expansion of the state's Department of Health (DOH), led by Commissioner Len Fishman. The governor



asked the Legislature to approve her plan to shape DOH into a new Department of Health and Senior Services.

Under the plan, Commissioner Fishman and his staff would develop and then oversee a "one-stop shopping" program for elderly New Jerseyans who are eligible for various health and social service benefits in which the state participates. As the plan has unfolded, however, many aspects of the state's huge Medicaid program also appear slated for transition into the new department. Until now, Medicaid has been a major component of the Department of Human Services (DHS), the largest agency in the state.

The change turns the heat up on a Medicaid program that already was approaching the boiling point. Tighter funding, DHS efforts to expand managed care for Medicaid recipients to increase access and quality while limiting costs, and congressional moves to change Medicaid into a "block grant" all have brought enormous uncertainty to the \$4 billion state program.

Besides senior services, the new "DH2S" will control health care regulation and public health.

## **GEOGRAPHIC VARIATIONS EMPHASIZED . . .**

A new "Atlas of Health Care" has been released by Dartmouth Medical School professor John Wennberg, MD, and The Robert Wood Johnson Foundation, in Princeton--and the driving theme is enormous, clinically inexplicable differences from one region to another.

As summarized in *Medicine & Health Perspectives*, the differences include rates of 1 percent in Rapid City, South Dakota, and 48 percent in Elyria, Ohio, for lumpectomies or partial mastectomies among elderly mastectomy patients. (The other patients received mastectomies that were not breast sparing.)

Supporting earlier Wennberg research that physician specialty supply correlates with higher volumes of procedures, the Atlas depicts back surgery rates among Medicare beneficiaries of 0.41 percent in San Diego and 0.11 percent in the Bronx. San Diego has almost two and one-half times as many orthopedic surgeons per population as the Bronx.

Expenditure levels also vary dramatically, according to figures contained in the Atlas. In Miami, per capita Medicare expenditures are 2.3 times as high as in Minneapolis.

Particularly perplexing was a finding that lower expenditures for inpatient services did not translate into higher expenditure levels for outpatient services or home health care. In short, where spending was higher for one setting, it also was high for other settings.

Publicity surrounding publication of the Atlas is expected to intensify efforts to cut spending in high-cost regions and to curtail the supply of procedure-oriented specialists.

In better news for many physicians, *Medicine & Health Perspectives* also reported a study conducted by 11 health care systems, KPMG Peat Marwick, and Northwestern University professor Stephen Shortell that identified "a clear trend toward greater physician-system integration."

Termed the Health Systems Integration Study, the examination produced a conclusion that "You can't do it without doctors. You don't have any choice." Consequently, physicians were found to be poised to acquire more seats on governing boards, more management positions, and more roles in which physicians could remain part-time practitioners while increasing their involvement on committees.

## **ANTI-KICKBACK CONVICTION AFFIRMED . . .**

A federal appeals court has affirmed the conviction, 18-month prison sentence, and \$40,000 fine of an internist accused of violating the Anti-Kickback Law by, in effect, raising office rent charges to a cardiologist in months when the internist referred more patients to the renter. The conviction was obtained partly through the testimony of the cardiologist-renter, who was given immunity from prosecution.

A summary of the case was supplied by Roseland attorney, Joseph M. Gorrell.

## **ETHICS PAPER DISSEMINATED . . .**

A white paper on "Professionalism in Health Care Delivery" has been prepared and widely distributed by the Bioethics Committee of the Milwaukee (Wisconsin) Academy of Medicine. The paper contains recommendations to increase the effectiveness of physician collaboration with other health professionals, support physician autonomy in managed care, preserve physicians' advocacy responsibilities toward patients, and improve clinical guidelines.



For a copy of the paper, contact Barbara Mihalik at MSNJ, telephone 609/896-1766, extension 263.

## **OPENINGS REMAIN IN SEMINAR SERIES . . .**

Positive evaluations for the unique, interactive seminar series, "Thriving in a Competitive Environment: Strategies for Success," have pleased MSNJ, The Academy of Medicine of New Jersey (AMNJ), and the Hospital Research and Educational Trust (NJHA/HRET), which arranged and cosponsored the six-part program. Unaccountably, however, registrations have not been commensurate with the evaluations.

Slots still remain for the final two sessions. "Strengthening Relationships with Your Patients" is the topic for Wednesday, March 20, 1996, at 9 a.m., to be team-taught by Dale A. Matthews, MD, of Georgetown University and Jan H. Gabin, Esq, of the Medical Inter-Insurance Exchange. "Negotiations and Legal Issues" will be discussed on Wednesday, April 17, 1996, at 9 a.m. by noted attorneys Alice G. Gosfield and Robert J. Conroy.

The sessions are held at MSNJ executive offices in Lawrenceville for \$175. To register, call Sondra Moylan at AMNJ, telephone 609/275-1911.

March 1996

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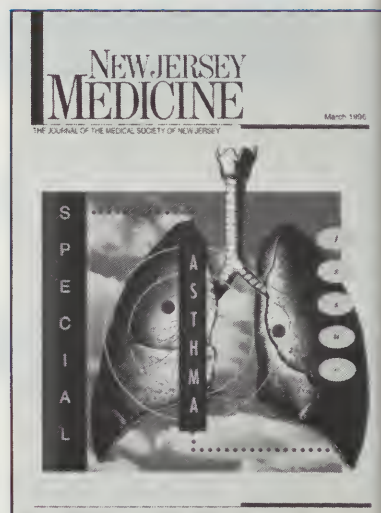


# NEW JERSEY MEDICINE

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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## On the Cover

Asthma is a serious national health problem that directly impacts health care costs. This special issue reports on asthma in New Jersey. Cover: Williams and Philips.

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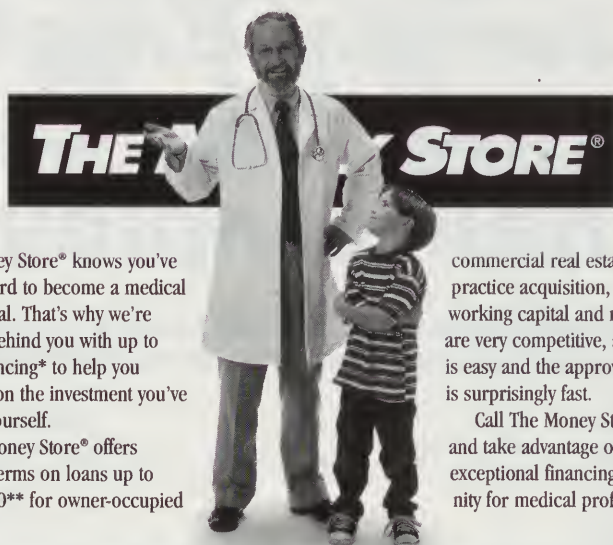
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# MSNJ NEWSLETTER

## MEDICAL WASTE TRACKING

New Jersey physicians now can count on gentler application of state law regulating medical waste transportation and disposal.

In a letter to physicians and other "generators" of regulated medical waste (RMW), the Department of Environmental Protection (DEP) Division of Solid and Hazardous Waste has announced a lifting of the requirement that all generators maintain detailed logs of RMW handling.

From now on, says DEP, generators either may retain their copy of the transporter's tracking form for all pickups or may keep their own tracking records. In either case, records must be sufficient to enable physicians to complete annual generator reports.

Also announced was a new policy permitting generators to

determine the frequency of pickups. Some RMW haulers had been advising physicians that monthly visits were necessary. But, RMW may not be stored on-site for more than one year.

For additional information, contact Robert M. Confer, chief, Bureau of Technical Assistance, at 609/984-6220.

Mr. Confer has cooperated with the committees and staff of the Medical Society of New Jersey (MSNJ) for several years in an effort to promote reasonable compliance with the state law.

The changes take effect immediately but are expected to be codified in state regulation later in the year. They were welcomed by MSNJ as reflecting its suggestions.

## SUBACUTE CARE GUIDELINES

Legislation allowing hospitals to set up subacute care units is wending slowly through the New Jersey Legislature. Coincidentally, the American Medical Association (AMA) has just released guidelines, recently approved by the AMA House of Delegates, describing the role of physicians in subacute care units.

The new "Guidelines for Physician Responsibilities in Subacute Care" calls for round-the-clock physician accountability and a strong role for the attending

physician in admission and discharge, continuity and coordination of care, and care planning. The guidelines further support establishment of a medical director for subacute care units.

Spirited opposition from the nursing home industry has impeded the New Jersey bill's progress.

Copies of the AMA guidelines are available to MSNJ members by calling Karen Monsees at 609/896-1766, extension 245.

## COMMUNITY SERVICE AWARD

The Physician Award for Community Service, sponsored by Wyeth-Ayerst Laboratories, is designed to recognize physicians who are actively engaged in the practice of medicine for the many and varied services above and beyond the call of duty they render to their respective communities.

Established in 1961, Wyeth-Ayerst Laboratories created the program with the belief that members of the health team should use all appropriate ethical means of improving and enlarging the stature of the physician, as a professional and as a participant in community life.

On behalf of MSNJ, Joseph



Riggs, MD, is soliciting nominations for this award. The recipient must be licensed in New Jersey; must be living; may not have received this award previously; and should have an outstanding rec-

ord of community service that reflects well on the physician. Nominations should be sent to Dr. Riggs, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

## PATIENT-CENTERED MEDICAL ETHICS

A program on medical ethics entitled, "Patient-Centered Medical Ethics," will be offered at the MSNJ Annual Meeting, on May 1, 1996, at 10 A.M., at the Trump Taj Mahal Casino/Resort in Atlantic City.

The program will include the presentation and discussion of a case history covering the implications for office, home, acute, and chronic care; from this, a comprehensive overview of ethical care will be developed. The primary objective is to incorporate principles of ethics into all projected and current treat-

ments for healthy, chronically ill, and acutely ill patients.

Joseph Fennelly, MD, will open the program. MSNJ President Louis L. Keeler will introduce the panelists. Panelists include Len Fishman, commissioner of health, Paul W. Armstrong, Esq., Edwin W. Messey, MD, Alan J. Lippman, MD, Susan M. Bauman, MD, and Michael A. Nevins, MD.

The participation of all guests as well as the general public is encouraged. This program is sponsored by The Academy of Medicine of New Jersey.

## ATTENDANCE AT MEETINGS OF THE MSNJ BOARD OF TRUSTEES July 1995-December 1995

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November 19 .....	Edwin M. Trayner, MD, president Andrew Kunish, MD Henry D. Rosin, MD Joan M. Basic, CAE, executive director
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October 15 .....	Martin Swiecicki, MD, president Emmons G. Paine, MD George J. Petruncio, MD
November 19 .....	Joseph W. Sokolowski, Jr, MD Martin Swiecicki, MD, president George J. Petruncio, MD Joseph Reichman, MD
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December 17 .....	Alan J. Lippman, MD, president-elect Anita Falla, MD

### Gloucester County

December 17 .....	Mitchell N. Kotler, MD, president
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### Hudson County

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September 17 .....	Mary Kay Basic, executive director	<b>Passaic County</b>	July 16 .....	Ramesh C. Tandon, MD, president
October 15 .....	Charles L. Cuniff, MD			Michael H. Bernstein, MD
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	Mary Kay Basic, executive director			Michael H. Bernstein, MD
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December 17 .....	Bernard Robins, MD			Frederic E. Wien, MD, vice-president
<b>Mercer County</b>				Michael H. Bernstein, MD
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September 17 .....	Anthony J. Ricketti, MD, president			Michael H. Bernstein, MD
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	Gabriel F. Sciallis, MD			Michael H. Bernstein, MD
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	Karl T. Franzoni, MD	October 15 .....		Paul J. Hirsch, MD
November 19 .....	Gabriel F. Sciallis, MD	November 19 .....		Paul J. Hirsch, MD
	Linda L. McGhee, executive director	December 17 .....		Paul J. Hirsch, MD
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December 17 .....	Karl T. Franzoni, MD			Richard H. Sharrett, MD
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	Palma E. Formica, MD			Melvin J. Goldberg, MD
	Howard D. Slobodien, MD	<b>New Jersey Chapter, American Academy of Pediatrics</b>	October 15 .....	Barry S. Prystowsky, MD
December 17 .....	David E. Swee, MD			Harris C. Lilienfeld, MD
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	Howard D. Slobodien, MD	October 15 .....		Robert H. Potts, Jr, MD
<b>Monmouth County</b>		November 19 .....		Robert H. Potts, Jr, MD
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	Edward A. Schauer, MD	<b>New Jersey Psychiatric Association</b>	July 16 .....	Linda G. Gochfeld, MD
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November 19 .....	Edward A. Schauer, MD	October 15 .....		Linda G. Gochfeld, MD
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October 15 .....	Rudolf E. Schwaeble, MD			
November 19 .....	Robert L. Steer, MD			
December 17 .....	Arganey L. Lucas, Jr, MD			



November 19 ..... Linda G. Gochfeld, MD  
 December 17 ..... Linda G. Gochfeld, MD

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July 16 ..... Kutumba S. Pitta, MD  
 October 15 ..... Melvin J. Goldberg, MD  
 November 19 ..... Melvin J. Goldberg, MD

#### Oncology Society of New Jersey

October 15 ..... Ismail Kazem, MD  
 November 19 ..... Ismail Kazem, MD

#### Radiological Society of New Jersey

July 16 ..... Julie Kelter Timins, MD  
 September 17 ..... Julie Kelter Timins, MD  
 October 15 ..... A. Frank Weitzman, MD  
 December 17 ..... Julie Kelter Timins, MD

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    Charles Heitzmann,  
    executive director  
 November 19 ..... Sherman Garrison, MD  
    Charles Heitzmann,  
    executive director  
 December 17 ..... Sherman Garrison, MD  
    Charles Heitzmann,  
    executive director

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    Jane Lorber, fellowette  
 October 15 ..... Christine Kline, president  
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 November 19 ..... Jane Lorber, fellowette  
 December 17 ..... Christine Kline, president  
    Jane Lorber, fellowette

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    Ralph J. Fioretti, MD  
    Donald J. Holtzman, MD  
    Joseph N. Micale, MD  
    Irving P. Ratner, MD  
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    Robert H. Stackpole, MD  
    Robert J. Weierman, MD  
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    Donald J. Holtzman, MD  
    Joseph N. Micale, MD  
    Fred M. Palace, MD  
    Irving P. Ratner, MD  
    William E. Ryan, MD  
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    Douglas M. Costabile, MD  
    Ralph J. Fioretti, MD  
    Joseph N. Micale, MD

Irving P. Ratner, MD  
 Joseph A. Riggs, MD  
 Robert H. Stackpole, MD  
 Robert J. Weierman, MD  
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    Donald J. Holtzman, MD  
    Joseph N. Micale, MD  
    Joseph A. Riggs, MD  
    William E. Ryan, MD  
    Robert J. Weierman, MD  
 December 17 ..... Harry M. Carnes, MD  
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    Donald J. Holtzman, MD  
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    Irving P. Ratner, MD  
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    A. Ralph Kristeller, MD  
    Mark T. Olesnick, MD  
    Fred M. Palace, MD  
    John W. Spurlock, MD  
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    Walter J. Kahn, MD  
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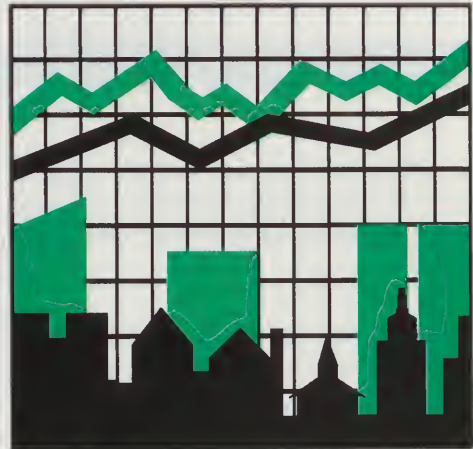
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#2



# DNR ORDERS

## HONORING DO NOT RESUSCITATE ORDERS

Good medicine requires that physicians anticipate and inform their patients of the "down side" of diagnosis and medical and surgical therapy. When inappropriately used, high technology medicine can profoundly interfere with the quality of patients' lives, prolong the dying process, and create unnecessary suffering for patients' families and loved ones.

Given the portability of modern medical technologies and treatments, use occurs outside as well as within inpatient facilities. When patients are terminally ill or medical treatment is futile, no process has been available for applying comfort measures while withholding aggressive resuscitation efforts in the home setting. Mobile intensive care units (MICU) are bound to administer efforts to maintain life.

An indepth study of these problems has been initiated by a number of concerned groups, particularly emergency physicians, the South Jersey Ethics Alliance, the New Jersey State Department of Health, and members of MICU and voluntary ambulance corps. It became clear that patients' private physicians represented the fulcrum on which procedures should be crafted for preventing inappropriate resuscitation of a dying patient at home.

Responding to a request from interested parties for input from MSNJ, the Committee on Biomedical Ethics created a sub-

committee chaired by Teresa M. Schaer, MD, and representing diverse groups. In the spirit of collaboration, consensus was accomplished.

Policies and procedures were developed whereby the patient's attending physician initiates and authorizes a process for honoring a prior do not resuscitate (DNR).

Prior directives (including living wills, medical power of attorney, and instructions about DNR) and advanced planning cannot assure an appropriate end of life therapy or rein in the relentless technologic imperative. Still, the addition of approved procedures helps to raise a safe umbrella for the doctor and patient. A trusting doctor-patient relationship is the bedrock for a successful outcome.

It is recognized that suggested changes in the "field" may be difficult to accomplish. Input from society, constitutional law, government, and the public sector is needed. Critique on this new policy is invited.

It remains, however, for physicians to continue to lead the way in developing processes to obtain what the late Dr. David Eckstein, the first chair of MSNJ's Committee on Biomedical Ethics, exhorted us to do: the best for the patient—not necessarily the most.

The following pages contain MSNJ's "Policy for Physicians"; "Policy for EMS Personnel"; and a patient compliance form.

# POLICY FOR PHYSICIANS

## Concerning *Do Not Resuscitate (DNR)* Orders for Patients Located Outside of a Hospital or Long-Term Care Nursing Facility

<b>Purpose</b>	To provide a process to allow patients to choose comfort measures over life support procedures by emergency medical services (EMS) personnel in case of cardiopulmonary arrest for designated patients who are located outside of a hospital or long-term care nursing facility.
<b>Definitions</b>	<p><i>DNR order:</i> A physician's order for a patient indicating that no basic or advanced cardiac life support efforts (as herein defined)<sup>1</sup> will be initiated in the event of cardiac and/or respiratory arrest.</p> <p><i>Valid prehospital DNR order form:</i> This form is valid if it is completed and signed by the patient/surrogate and the patient's attending physician. Legible photocopies are acceptable. A copy is printed at the end of this article.</p> <p><i>DNR bracelet (optional):</i> A DNR bracelet is a MSNJ-approved, official, distinctive, and easily recognizable medical bracelet worn on the wrist or on a chain around the neck signifying that the patient has an effective DNR order in place. Such a bracelet shall be accepted by EMS and other medical providers as conclusive evidence that the patient has a valid DNR order in effect and resuscitative treatment should be withheld.</p> <p><i>Basic life support (BLS):</i> BLS is the phase of emergency care that includes recognition of cardiac arrest, access to the EMS system, and basic CPR. Basic CPR is the attempt to restore spontaneous circulation using the techniques of chest wall compressions and pulmonary ventilation.</p> <p><i>Advanced cardiac life support (ALS):</i> This term refers to attempts at restoration of spontaneous circulation using basic CPR plus advanced airway management, endotracheal intubation, defibrillation, and intravenous medications.</p> <p><i>EMS personnel:</i> First responders (police, fire, and others trained in CPR); emergency medical technicians staffing ambulance services (paid or volunteer); mobile intensive care paramedics; and nurses who staff mobile intensive care units.</p> <p><i>Surrogate decision maker:</i> The parent or guardian of a minor child; closest relative of an adult patient lacking decision-making capacity; the legal proxy as contained in an advance directive; or the court-appointed guardian of a judicially declared incompetent patient.</p>

### Policy

#### A. Respect for the wishes of patient and family

1. Unless a DNR order is written by a physician for a patient found to be in cardiopulmonary arrest outside the hospital or long-term care facility, full resuscitative efforts will be initiated by EMS personnel.
2. When deciding whether to write a DNR order, the physician(s) must not overrule the wishes of the patient/surrogate.
3. A DNR order may be revoked at any time by the patient or another in the patient's presence at the patient's direction by the cancellation or destruction of the DNR order form and bracelet; or by an oral expression by the patient of intent to revoke; or by the patient's attending physician or at the direction of the surrogate decision maker.



## B. Criteria for DNR orders

1. The DNR order is requested by a mentally competent, informed, adult patient, or for the incompetent or minor patient by the closest relative, the court-appointed guardian, or the surrogate decision maker.
2. In considering the appropriateness for a patient/surrogate request for an out-of-hospital DNR order, factors such as the following warrant discussion with the patient/surrogate:
  - a. The life-sustaining treatment is likely to be ineffective or futile, or is likely to merely prolong an imminent dying process.
  - b. The patient is permanently unconscious.
  - c. The patient is in a terminal condition.
  - d. There is a chronic debilitating disorder or the burdens of resuscitation significantly outweigh the benefits.
  - e. Such other factors as may be unique to the patient's condition.

## C. Relation to other care

1. A DNR order enhances the professional responsibility to provide comfort and all other needed care.

## Physician Procedure

1. Obtain written informed consent from the patient/surrogate.
2. Complete prehospital DNR order form. Place copy of form in patient's medical record. Give several copies to patient, family, and caregivers outside the hospital or nursing home.
3. Instruct patient and caregivers as to the use of the prehospital DNR order form and as to the appropriate means of displaying the prehospital order DNR form, i.e. placed prominently in the home in areas such as the patient's headboard, bedstand, bedroom door, or refrigerator.
4. Additionally, a patient may choose to wear an appropriately recognized DNR bracelet. The bracelet shall be considered a valid indication for prehospital DNR. The physician shall inform the patient/surrogate of the availability of DNR bracelets as an additional means of alerting EMS personnel and the means to obtain DNR bracelets.
5. Review the DNR status periodically with the patient/surrogate, revise the treatment plan if appropriate, and document any changes in the patient's medical record. If the DNR order is revoked, provide instructions for the destruction of the order and the removal of the bracelet.

## Additional Recommendations Regarding Documentation of Order

It is recommended that the physician place a note in the patient's office medical chart about the DNR order, which should include the following information:

- a. Diagnosis.
- b. Reason for DNR order.
- c. Patient's capacity to make decision.
- d. Documentation that discussion of DNR status has occurred and with whom.

## Revocation of DNR Orders

1. A DNR order may be revoked at any time by the patient or another in the patient's presence at the patient's direction by the cancellation or destruction of the DNR order form and bracelet; or by an oral expression by the patient of intent to revoke; or by the patient's attending physician or at the direction of the surrogate decision maker.

<sup>1</sup> *Textbook of Advanced Cardiac Life Support*, American Heart Association, 1994.

# POLICY FOR EMS PERSONNEL

## Concerning *Do Not Resuscitate* (DNR) Orders for Patients Located Outside of a Hospital or a Long-Term Care Nursing Facility

- Purpose** To provide a process to honor a patient's refusal of emergency life support procedures by emergency medical services (EMS) personnel in case of cardiopulmonary arrest for designated patients who are located outside of a hospital or long-term care nursing facility.
- Definitions**
- DNR order:* A physician's order for a patient indicating that no basic or advanced cardiac life support efforts (as herein defined)<sup>1</sup> will be initiated in the event of cardiac and/or respiratory arrest.
- Valid prehospital DNR order form:* This form is valid if it is completed and signed by the patient/surrogate and the patient's attending physician. Legible photocopies are acceptable. A copy is printed at the end of this article.
- DNR bracelet (optional):* A DNR bracelet is a MSNJ-approved, official, distinctive, and easily recognizable medical bracelet worn on the wrist or on a chain around the neck signifying that the patient has an effective DNR order in place. Such a bracelet shall be accepted by EMS and other medical providers as conclusive evidence that the patient has a valid DNR order in effect and resuscitative treatment should be withheld.
- Basic life support (BLS):* BLS is the phase of emergency care that includes recognition of cardiac arrest, access to the EMS system, and basic CPR. Basic CPR is the attempt to restore spontaneous circulation using the techniques of chest wall compressions and pulmonary ventilation.
- Advanced cardiac life support (ALS):* This term refers to attempts at restoration of spontaneous circulation using basic CPR plus advanced airway management, endotracheal intubation, defibrillation, and intravenous medications.
- MICU personnel:* Certified paramedics or MICU nurses trained in the provision of advanced cardiac life support and affiliated with a state-approved MICU program.
- Other EMS personnel:* First responders (police, fire, and others trained in CPR); and emergency medical technicians staffing ambulance services (paid or volunteer).
- Resuscitative efforts:* Those treatments rendered to a patient in cardiopulmonary arrest (no pulse, no respirations) including CPR, endotracheal intubation, defibrillation, and the delivery of emergency cardiac drugs.

### Policy

- A. Indication: The valid prehospital DNR order shall be honored by MICU/EMS personnel if:
1. The valid prehospital DNR order form is available to EMS personnel or prominently displayed on a headboard, bedside stand, bedroom door, or refrigerator **OR** the patient is wearing an appropriately recognized DNR bracelet.
  2. The valid prehospital DNR form is signed and dated by the patient/surrogate and by the patient's attending physician.
  3. If the foregoing conditions have been met there is no basis to override the DNR order.
  4. EMS personnel shall honor a contemporaneous revocation of the DNR order by the patient or surrogate.



- B. Relation to other care: EMS personnel should provide all appropriate treatment to the patient with a valid prehospital DNR order, except CPR and resuscitative efforts.

### **Procedures**

- A. If the patient is in cardiopulmonary arrest with a valid prehospital DNR order, the EMS personnel should:
1. Assess the patient for the absence of breathing and/or heartbeat.
  2. If the EMS personnel are on the scene without MICU, follow local protocol for obtaining pronouncement.
  3. For MICU personnel, contact base station physician to relay patient assessment and the existence of a valid prehospital DNR order form; pronounce patient, through base station physician, according to MICU pronouncement protocols.
- B. If the patient with a valid prehospital DNR order is not in cardiopulmonary arrest, the EMS personnel should:
1. Assess the patient.
  2. Provide all appropriate treatment.
  3. Provide transportation to the hospital if appropriate.
  4. Honor the valid prehospital DNR order if cardiopulmonary arrest occurs during transport.
  5. Provide a copy of the valid prehospital DNR order to the receiving hospital if available.

### **Documentation**

- A. Document all appropriate patient information and clinical assessment on patient run form.
- B. Document valid prehospital DNR order information, e.g. name of attending physician and date; attach a copy of valid prehospital DNR order form to the patient run form.
- C. Follow local EMS protocol for pronouncement documentation.

### **Quality Assurance**

- A. All instances wherein patients present to MICU with prehospital DNR orders must be retrospectively reviewed by the MICU medical director.
- B. Any deviations by MICU from prehospital DNR order protocols must be reviewed and addressed promptly by the MICU medical director.
- C. It is recommended that all BLS services develop a quality assurance mechanism for the retrospective review of compliance with prehospital DNR protocols.

<sup>1</sup> *Textbook of Advanced Cardiac Life Support*, American Heart Association, 1994.

Medical Society of New Jersey

MSNJ

I, \_\_\_\_\_ request no resuscitative attempts in the event of a cardiac or respiratory arrest. In consenting to this DNR order, I understand that if my heart stops beating or if I stop breathing, no medical procedures will be instituted to revive me.

I expect this order to be honored by all EMS personnel and all hospital and health care providers with whom I may have contact during a medical emergency.

Patient address \_\_\_\_\_  
\_\_\_\_\_

Patient/surrogate signature \_\_\_\_\_

Surrogate relationship to patient \_\_\_\_\_

Surrogate address \_\_\_\_\_  
\_\_\_\_\_

***ALL FIRST RESPONDERS/EMERGENCY MEDICAL SERVICES PERSONNEL***

**DO NOT RESUSCITATE**

**YOU ARE AUTHORIZED TO COMPLY WITH THIS PREHOSPITAL DNR ORDER.**

**THE ABOVE-NAMED PATIENT IS UNDER THE CARE OF THE PHYSICIAN LISTED BELOW.**

Physician name \_\_\_\_\_

Physician signature \_\_\_\_\_

Physician address \_\_\_\_\_  
\_\_\_\_\_

Physician telephone number (\_\_\_\_) \_\_\_\_\_

Medical facility affiliation \_\_\_\_\_

***THIS DOCUMENT SHOULD BE PROMINENTLY DISPLAYED AND READILY AVAILABLE TO EMS PERSONNEL***



## INSTRUCTIONS FOR FIRST RESPONDERS/EMS

***ALL PATIENTS HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS INCLUDING THE RIGHT TO ACCEPT OR REFUSE LIFE-SAVING MEDICAL TREATMENT.***

1. Assess patient for absence of breathing and/or heartbeat.
2. If this patient is not in cardiopulmonary arrest, provide all necessary care, including transport if required.
3. If the patient is in cardiopulmonary arrest, do not initiate CPR and resuscitative efforts.
4. Follow your local EMS protocols for pronouncement.
5. Document all pertinent information on your run sheet and attach copy of the DNR prehospital order.

**IF YOU HAVE ANY QUESTIONS CONCERNING THE TREATMENT AND/OR PRONOUNCEMENT OF THIS PATIENT, CALL:**

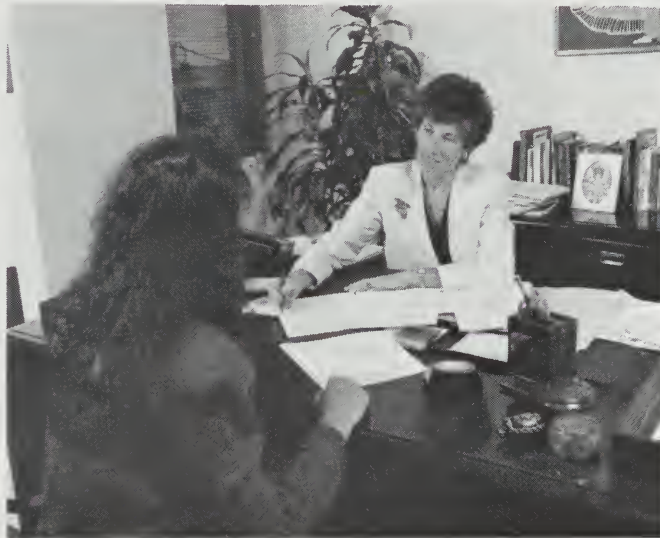
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**Federal crackdown.** Pennsylvania hospitals have served as canaries in the coal mine for health care providers who have followed Medicare and Medicaid payment policies with less than scrupulous adherence. As reported recently in the "Health Care" supplement of the *New Jersey Law Journal*, the U.S. Justice Department initially demanded triple damages from approximately 200 facilities concentrated in the western portion of the Keystone State.

The article, authored by Princeton attorneys Ivan J. Punchatz and Keith S. Grube, summarizes negotiations between the Justice Department and a task force formed by the hospitals. Under the proposed agreement, the accused hospitals would be clustered into three tiers, depending on their ratio of bad claims to Medicare-reimbursed beds.

Hospitals placed in the tier with the highest ratios still would face triple damages for claims dating from a late audit period.

Encompassing a review of claims for a nine-year period ending in 1991, the Justice probe focused on outpatient tests conducted within 72 hours of admission. Under Medicare billing rules, tests performed during this three-day window are included within the inpatient umbrella and should not be billed separately.

But, warns Punchatz and Grube, other types of violations also will incur federal wrath as the probe widens to other states and other categories of providers.

For example, the authorities are looking for suppliers who double-bill by seeking reimbursement under both Part A and Part B of Medicare. Also at risk are unbundled outpatient surgery claims.

Enforcement is proceeding under the Federal False Claims Act. Initially intended to catch profiteers who sold poor-quality or overpriced goods to the Union army, the Act prescribes penalties of three times the amount of the disputed claim plus mandatory fines of \$5,000 to \$10,000. Prosecutors need not prove specific intent to defraud—only that the claim was false and submitted with reckless disregard of its truth or falsity.

As reported, the proposed agreement would oblige the hospitals to adopt measures intended to prevent billing errors. The agreement includes a so-called "safe harbor" for hospitals that make some errors subsequently. These later mistakes will be considered inadvertent in view of the monumental difficulty of achieving a 100 percent rate of accuracy in claims that easily can number 600 Medicare-reimbursed stays for an average-sized hospital per year.

**UMDNJ impact.** In a printed report on its "economic impact," the University of Medicine and Dentistry of New Jersey (UMDNJ) estimates its annual contribution to the Garden State's economy at \$1.7 billion, or roughly twice its budget and five times its state funding allotment.

The estimate flows from a finding that UMDNJ and its employees and students spend approximately \$458 million in the state per year. These dollars are assumed to be recycled once within the state. The resulting \$916 million product was added to the \$785 million budget to determine the impact. The 1994 figures were used.

Last year, UMDNJ celebrated its silver anniversary. President Stanley S. Bergen, Jr, MD, has been at the helm throughout the academic vessel's history.

**Community health.** Anxious to encourage the state's hospitals to enrich their ties to surrounding communities, the New Jersey Hospital Association (NJHA) has created a New Jersey Society for Community Health Assessment and Improvement.

The formation of the new group is a partial outcome of NJHA's major community health initiative.

Another outcome is enhanced attention to minority health. NJHA found that seven causes of death accounted for 80 percent of minorities' excess mortality—with life expectancy for African-Americans at 69 years compared with 75 years for the overall population. The seven stalkers of minorities are cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide/suicide and unintentional injuries, infant mortality, and AIDS.

## MALPRACTICE VERDICTS

**Attempted suicide.** A drug overdose and sudden onset of paranoid behavior led a full-time carpenter in his early 20s, with no previous psychiatric history, to be

admitted to a hospital. There, on the first day after admission, he attempted to slit his wrists. Elevated blood pressure and blood sugar levels were noted.

The patient's psychiatrist entered a psychiatric diagnosis. Six weeks after admission, the patient left against medical advice.

A few days later, the patient's



family physician referred him to a different hospital, where he was admitted to the psychiatric unit. During a one-month stay, a new psychiatrist determined that the patient was not suicidal. At the conclusion of this period, the patient jumped from a second-story window. The fall caused severe fracturing in the leg.

Subsequent blood testing revealed that the patient was suffering from Cushing's disease, an endocrine condition that leads to psychotic behavior but can be cured through removal of a tumor in the pituitary gland. This intervention, in fact, did prove successful, but the patient brought a malpractice action in New Jersey against both psychiatrists and hospitals, claiming that the misdiagnosis and related errors caused his injuries.

An expert psychiatrist testified on behalf of the plaintiff that the sudden appearance of delusional behavior, high blood pressure, and a heightened blood sugar level should have alerted the defendants to the possibility of a nonpsychiatric explanation and to the need for further testing.

The defense, however, observed that the patient had not presented with the classic symptoms of Cushing's disease. These symptoms, which are similar to signs of long-term use of steroids, include a moon-faced aspect, discoloring on the abdomen resembling stretch marks, and a fatty deposit, termed a "buffalo hump," on the back.

Also at issue was the extent of the patient's injuries. The plaintiff claimed permanent and extensive pain and restriction involving the foot as a result of shattering fractures of the heel and several metatarsals and ensuing surgery. He also asserted permanent full-time disability.

To counter some of the disabili-

ty and injury claims, the defense presented testimony by a former physical education instructor retained as a detective by the defendants to determine the plaintiff's level of physical functioning.

The detective testified that he had difficulty keeping up with the plaintiff as the latter ran through a train station and stood, rather than sat, while waiting for a train. This testimony was bolstered by a videotape taken by the detective. The jury found for the defendants.

**Cataract surgery.** A 64-year-old widow, not currently employed, was scheduled for cataract surgery. She sustained an upper respiratory infection that had subsided, except for a lingering cough. The surgery proceeded as planned. During the procedure, performed under a local anesthetic, the patient suffered a coughing fit. The resulting increase in intraocular pressure forced the vitreous, lens, and a portion of the iris to extrude, causing complete blindness in the eye.

In a New Jersey court the patient sued the ophthalmologist and anesthesiologist for malpractice in failing to cancel or halt the surgery. The plaintiff related that she had telephoned the ophthalmologist several days before the operation to advise him of her symptoms and inquire about a postponement. According to her recollection, the physician reassured her that the procedure could be accomplished safely and that he would administer decongestants if necessary.

While on the gurney prior to surgery, the plaintiff continued, she suffered a severe coughing spell that induced a nurse to ask the ophthalmologist about cancelling the procedure. A graphic description of the extrusion was provided for the jury.

An expert ophthalmologist testified for the plaintiff that a persistent cough creates a risk of extrusion, and that the operation should have been delayed. The plaintiff maintained that a delay of ten days would have had no adverse consequences.

The defendant eye surgeon presented his operative report, which noted that the patient had advised that she did not want to delay the surgery, due to the severity of her vision problem, and had indicated an ability to control her cough. The plaintiff discounted the report on the grounds that it was dated two weeks after the incident, but the defendant blamed the delay on a defect of the recording equipment.

The defendant anesthesiologist protested that he had no prior knowledge of the extent of the cough or any prior conversations about a delay. In any event, he insisted, the surgeon was in a better position than he to determine the level of risk.

Six years after the event, the plaintiff related that she continues to experience soreness in the eye. She added that she has been highly concerned about vision loss in the other eye. After a period of deliberation, she subsequently underwent a successful cataract removal in the other eye at a regional eye hospital but has developed some signs of glaucoma. Two friends testified that she no longer is as gregarious as formerly and has restricted her activities.

The jury found the anesthesiologist not negligent, the ophthalmologist negligent, and damages of \$3,500,000. This award was considered "particularly substantial" by commentators.

□ James E. George, MD, JD;

Neil E. Weisfeld, JD, MSHyg

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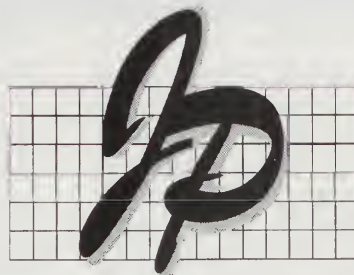
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# BOOK REVIEWS

## MOLECULAR GENETICS OF CANCER

John Cowell. Oxford, London, BIOS Scientific Publishers, 1995. Cancer is a genetic disease. Every malignant characteristic, from tumor initiation to growth and differentiation, can be explained by alteration or mutation of gene function. The host's capability for tumor suppression is genetically determined, as well.

Progress in the elucidation of genetic functions in malignancy has been rapid and impressive, although true understanding of the complex molecular mechanisms remains elusive.

This up-to-date review of cancer genetics, written by leading experts from North America

and Europe, provides the reader with information relating genes and the development and progression of human cancer. Specific chapters deal with retinoblastoma, Wilm's tumor, rhabdomyosarcoma, and breast, ovarian, colon, and lung cancers. Other chapters consider multiple endocrine neoplasia and the role of the p53 tumor suppressor gene.

All material is richly referenced. Although relatively brief (241 pages), the book presents a comprehensive overview of current perceptions regarding the molecular biology of cancer. □ Alan J. Lippman, MD

## UNDERSTANDING DEATH

*Death with Dignity: Making Choices and Taking Charge*, Dr. Timothy Quill. *How We Die: Reflections on Life's Final Chapter*, Dr. Sherwin Nuland. Physicians need a language, a map, and a moral compass to navigate between the cold objectivity of science and the danger of losing professionalism in an over-subjective identity with the patient. This is no easy task; but this labor is given voice and shape by Drs. Quill and Nuland.

Dr. Quill's book, *Death with Dignity: Making Choices and Taking Charge*, was fueled by his "desire to increase the options available to dying patients . . . and to challenge the medical profession to take a more personal, in-depth look at end-of-life suffering . . . from the vantage point of someone who had gone over the edge in terms of what is orthodox medical ethics."

His patient, Diane, struck with acute leukemia and seeking assurance on how to avoid unbearable pain, is instructed by the Hemlock Society to obtain a

prescription for barbiturates. Dr. Quill's defining moment is when he accedes to her request and becomes the agent for Diane's control; he writes, "I wrote the prescription with an uneasy feeling." In response to his actions, Dr. Quill received support from many respected medical sources and families who experienced guilt for not having done more for their deceased relatives.

Personal experiences did much to shape Dr. Quill's perception of moral obligations. These experiences show the absence or presence of empathy and the ability of physicians to listen with "the third ear."

Dr. Quill emphasizes that there are limits to hospice care and pain relief. He questions whether the Hippocratic Oath goes far enough toward a deeper engagement and nonabandonment of the suffering patient.

Building on the Dutch experience where physician-assisted suicide is not punishable by law, he recommends that doctors supply the drugs, but avoid active

participation and that physicians maintain a continuum of comfort care.

Concise chapters on advance directives and challenges to institutions and physicians are well expressed. He ends with the "lingering regret that Diane died alone," of her own free will and choice.

Dr. Nuland's book, *How We Die: Reflections on Life's Final Chapter*, was written "to demythologize the dying process . . . not to depict it as a horror-filled sequence of painful and disgusting degradations but to present it in its biological and clinical reality, as seen by those who witness it and felt by those who experience it." According to Dr. Nuland, "Both the doctor and the patient should experience the dying process. By knowing the truth and being prepared for it, what we divest ourselves of is that fear of the terra incognita of death that leads to self-deception and disillusion."

Dr. Nuland's descriptions of deaths from AIDS are wrenching: "When children predecease their parents it is a curse, a scourge; the dying consumes the intellectual energy of moralist and litterateurs nowadays. We are all diminished by this disease."

His science is tutored by a deep intuition, and he applies this yardstick to the discussion of euthanasia "or shades thereof." He argues, as does Dr. Quill, for "empathy, unhurried discussion, consultation, questioning, and challenging assumptions."

Both doctors stress the priority of having a physician who is a trusted friend. Dr. Nuland writes,

"There are so many ways to travel through the thickets; so many choices: where to stop, to go on, to say enough is enough—until the last steps we need the company of those we love. . . . At such times it is not the kindness of strangers we need, but the understanding of a longtime medical friend. In whatever way our system of health care is reorganized, good judgment demands that this simple truth be appreciated . . . we should mourn the loss of love . . . understand the reality of illness . . . we are part of the ecosystem."

In the chapter, "The Lessons Learned," Dr. Nuland stresses that in the quest to solve the riddle of disease, in this search for absolute truth, we may abandon the patient through bypassing the spiritual work of empathetic understanding: The result is to deny ourselves and our patient the experience of mutual wounding that may well be the central act of healing.

In these books, Drs. Quill and Nuland tell us a great deal about themselves. They also construct a spiritual structure enabling the physician to complete the empathetic fusion of two persons, patient and doctor, who share the pain and suffering of illness and death.

Together, driven by compassion, two doctors have spoken. These books are food for thought and a form of soul food—the kind that nurtures the spirit and helps us understand medicine as a spiritual experience. This is sustenance for any age. □ Joseph F. Fennelly, MD



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# EDITOR'S DESK



AULD LANG SYNE

Auld lang syne means "old long since," referring to times long ago, although long is a relative term.

This issue of *NEW JERSEY MEDICINE* (NJM) is the last in its present configuration. The April publication will present a new image.

About one year ago, the Strategic Planning Task Force of the Medical Society of New Jersey (MSNJ), meeting in a retreat with members of the Board of Trustees, produced a far-reaching document to change the activities and impact of MSNJ. The recommendations were approved by the entire Board of Trustees in open session and then submitted to the House of Delegates at its Annual Meeting.

Several items in the report were of particular importance to this magazine. Objective VII-3 of the committee report said, "Advance NJM as the major health policy publication in New Jersey and expand its readership beyond the membership and physician community." In the same section it recommended that we "encourage development of a communication system whereby physicians will be kept abreast of the ever-changing regulations affecting their practices" and that we "keep physicians informed of evolving health care changes." And the report asked that some standing committees be abolished, their functions to be assumed elsewhere, and that others be merged. In the latter category was the Committee on Publication, which was to be combined with the Council on Public Relations into a new Council on Communications.

These recommendations were adopted, after searching debate at

the reference committee hearings and on the floor of the House of Delegates. (The complete and approved report of the Strategic Planning Task Force can be found in the 1996 *Policy Compendium*, released earlier this year.) Resolution #42, which had asked that emphasis be maintained on scientific articles, also was adopted as amended: Resolved, that the medical scientific integrity of NJM be preserved under any organizational change. (It is of interest to note that resolutions in previous years had requested that more emphasis be placed in NJM on socioeconomic and other non-clinical matters.)

The merging of the two committees necessitated organizational changes. Interested members of the Committee on Publication were absorbed into the new council and it was evident that the former Editorial Board needed revision and broadening. Thus, a new Review Board was established. President Louis L. Keeler wrote to prospective members of this new board in July 1995, asking them to accept appointment.

Currently, we are in the process of changing the magazine in three ways:

- Altering the content, to focus more on health policy instead of strictly clinical aspects of care.
- Seeking a wider readership to include the state's health policy and health care community as well as our member physicians.
- Updating the format and design.

Dr. Keeler wrote that the primary goal of NJM "is to inform the architects of health policy in New Jersey by providing accessible, understandable, accurate, timely, and relevant information about events, trends,

findings, and perspectives in health care and public health." He also noted that the Review Board would be assisting the editor-in-chief in:

1. Determining topics for commissioned articles.
2. Reviewing contributed articles from time to time.
3. Providing viewpoints for inclusion in opinion pieces in the journal, such as the letters page and a point counterpoint feature.
4. Selecting a person of the year, who will be profiled.
5. Reviewing and approving an annual review of NJM.

There was broad acceptance of the invitation by prominent figures in many walks of life, including physicians, nurses, legislators, former members of the Editorial Board, key personnel of the staff of MSNJ, and heads of hospital associations, managed care groups, foundations, other medical societies, labor unions, and more. The preliminary meeting of the Review Board, held in November 1995, produced gratifying attendance and participation, and a variety of innovative suggestions for the future. Although some caveats were issued, there was general agreement that the project was worth doing. We intend to do it well.

The letter and the spirit of Resolution #42 will be observed. We will continue to encourage the submission of clinical and other scientific papers by readers. We also will continue to encourage our younger colleagues and the future members of our noble profession to participate, by letter, manuscript, or personal contact. We will maintain membership services. If there are fewer scientific articles in each issue of the periodical, we expect that the overall quality will be



higher. If we receive substantial numbers of worthwhile papers, we can arrange for special supplements or special methods of distribution. (More on that next month.) There will be increased emphasis on public health topics, which will be the continuance of an existing trend; many of our scientific papers and special issues have dealt with those concerns. But articles on health policies and socioeconomic topics, which consume so much of our thoughts and energies in today's world, will predominate.

In 1987, George Lundberg, editor-in-chief of the *Journal of the American Medical Society (JAMA)*, outlined the "Critical Objectives" of *JAMA*. In addition to publishing properly peer-reviewed scientific reports and providing educational experiences for physicians, the objectives included:

- Forecasting medical issues and trends.
- Fostering debate on controversial issues.
- Informing readers about nonclinical political, philosophical, ethical, legal, social, economic, historical, and cultural components of medicine.
- Improving public health worldwide.
- Accepting a social responsibility for the journal.
- Providing a readable and quality publication.

The *New England Journal of Medicine (N Engl J Med)* is the other respected and oft-quoted internationally distributed magazine familiar to most of our readers. In 1995, Jerome P. Kassirer, its editor-in-chief, outlined his policies and opinions regarding the journal's functions, "The journal's stock in trade continues to be the publication of the best, most important, and most original clinical research. . . . In addition to reports of original research, the journal continues to publish a rich variety of articles on health care financing and delivery, outcomes research, and

medical ethics." Dr. Kassirer enthusiastically listed some of the additional new pedagogical features, including clinical problem-solving, molecular medicine, and increased numbers of articles on basic research. Clinical research, as he acknowledges with pride, is where his principal efforts will lie.

Both *JAMA* and *N Engl J Med* serve their constituencies well. But I feel that each has changed direction and emphasis in recent years. The scientific articles in *JAMA* seem more public health oriented than heretofore, and greater emphasis is noted in the other objectives as itemized by Dr. Lundberg. *N Engl J Med*, in contrast, and as directed by Dr. Kassirer, has emphasized its scientific content, particularly in the basic sciences, and seems to have diminished the "rich variety" of articles dealing with other than basic or clinical research.

We do not expect *NJM* to become another *Journal of the American Medical Association* or *New England Journal of Medicine*. That would be unrealistic and quixotic. We can, however, become a state version of *JAMA*, one with broad appeal to all who deal with illness, injury, and disease, directly or tangentially. We can give evidence of the academic strengths of the institutions, researchers, and physicians in New Jersey by choosing pertinent and properly peer-reviewed scientific manuscripts, and we can give proper weight to public health matters, to health care delivery systems, to the medically underserved, to the economic problems associated with burgeoning technology, to the new ethics associated with advances in diagnosis and treatment, to the blurring of lines previously separating various providers of care, and to a myriad of problems not dreamed of only a handful of years before.

The new *NJM*, like any neonate, cannot survive on its own. It needs the nourishment of a continual flow of materials. We

count on the input from those who have served on the Committee on Publication and on the Editorial Board and who continue to serve on the reconstituted panels, we count on the input from others on the prestigious Review Board, and I hope we can count on you, the reader, for whom we make these efforts.

Additional commentary on the changes in the magazine will be given in the April issue, when you will have the opportunity to criticize the results first-hand.

**Special issue.** Although I have noted an occasional wheeze, I do not feel qualified to develop an original theme on the subject of asthma. Len Bielory, MD, and his associates and colleagues, on the other hand, demonstrate clearly the depths of their knowledge and their abilities to communicate their scholarship in this special issue devoted to a medical problem of increasing prevalence, morbidity, and mortality. I hope you will enjoy and appreciate their efforts as much as I have, even if you are wheeze-less. They deserve many thanks. □ Howard D. Slobodien, MD

*It is change, continuing change, inevitable change, that is the dominant factor in society today. No sensible decision can be made any longer without taking into account not only the world as it is, but the world as it will be. . . . This, in turn, means that our statesmen, our businessmen, our everyman must take on a science fictional way of thinking.*

Isaac Asimov,  
*The Encyclopedia of  
Science Fiction*, 1978

*The difficulty lies, not in the new ideas, but in escaping from the old ones, which ramify, for those brought up as most of us have been, into every corner of our minds.*

John Maynard Keynes,  
*The General Theory of  
Employment, Interest  
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# Asthma: The disease and its management

Leonard Bielory, MD

*Asthma is a serious national health care problem with a direct impact on health care costs. Individuals of all ages are affected by this chronic disorder, which can be severe and sometimes can be fatal. A better understanding of asthma will help reduce health care costs.*

Asthma is derived from the Greek and means to blow or breathe hard. Asthma is a lung disorder marked by attacks of breathing difficulty, wheezing, and coughing as well as by thick mucus within the airways of the lungs. In asthma, the airways (bronchi) lumen become smaller due to several ongoing processes: the lining of the airway swells due to fluid buildup (edema); constriction of the bronchial muscle; infiltration of immune system cells into the bronchial walls; and secretion of a thick mucus directly into the lumen. As a result, the diameter of the patency of the airway decreases significantly.

Thus, asthma has been defined as an airway disease that is characterized by airway inflammation, increased airway responsiveness, and generally reversible airway obstruction. Inflammation plays a central role in the pathophysiology of asthma. The inflammatory infiltrate, reflected by the enormous increased presence of immune cells is common to asthma at all stages and is directly related to the development of bronchial hyperresponsiveness. The increased sensitivity and response of the air-

ways to nonspecific stimuli that have little or no effect on airways of normal persons, e.g. cold air, strong odors, cigarette smoke, exercise, is a hallmark of asthma. In patients with asthma, the airway obstruction reverses with treatment, but in some persons this reversibility is incomplete. The severity of asthma is dependent on the amount of fixed obstruction that also correlates to increased nocturnal awakenings, increased use of short-acting inhaled bronchodilators, and decreased quality of life.<sup>1</sup>

## HISTORY

Allergies are the most common cause of asthma. Over 90 percent of asthmatic children less than 16 years of age have allergies; 70 percent of asthmatics aged 16 to 30 years old are allergic; and one-half of the asthmatics over the age of 30 years are allergic. The allergic reaction is dependent on environmental allergens, the IgE antibody, and the mast cell. Allergens are proteins that are commonly derived from natural organic sources such as house dust, pollens, mold spores, and insect and animal emanations. These allergens are responsible for

rhinitis, conjunctivitis, urticaria, anaphylaxis, and asthma. Inhalant allergies may be seasonal, episodic, or perennial. Seasonal allergens are plant pollens that predominantly pollinate by the air. Contrary to popular belief, "rose fever" or "hayfever" are neither allergies to roses or hay nor fevers, but represent the temporal relationship to pollen released during the blooming of roses in the spring (grass pollen) and at the end of the summer (ragweed pollen). Three out of four patients with allergies are allergic to ragweed. Details of pollen in New Jersey can be obtained by calling the Pollen Count Hotline at UMDNJ-New Jersey Medical School/University Hospital, at 201/982-6518.

## LABORATORY FINDINGS

Pulmonary function tests are the most important tests used in the diagnosis and assessment of asthma. Spirometry, which can be done in the office setting, measures the forced expiratory flow rate over one second (FEV<sub>1</sub>), forced vital capacity (FVC) over three to six seconds, and the maximum mid-expiratory flow rate that is the slope of the line between 25 percent and 75 percent of the FVC. These are the essential measurements that assist in the diagnosis of obstructive lung disorders. In severe asthmatics, both the FVC and FEV<sub>1</sub> may be reduced, reflecting some obstruction and restriction. A severely impaired FEV<sub>1</sub> with a

normal FVC suggests severe obstruction alone. In mild obstruction, both the FEV<sub>1</sub> and FVC may be normal, but the mid-expiratory flow rate is reduced. Flow volume loops describe both the inspiratory and expiratory phases of breathing and can provide important insight into the site of obstruction.

The peak expiratory flow (PEF) rate is an important clinical tool in the office, hospital, emergency room, and home. It is simply the peak or maximum flow rate generated during the maximum forced expiratory effort. It is a simple test that correlates to the FEV<sub>1</sub> with measured correlation coefficients in the range of 0.75 to 0.85.<sup>2,3</sup> The PEF can be easily done at home with a peak flow meter.

Allergy skin testing represents the best diagnostic method for confirming allergy to inhaled pollens and animal danders and for which allergens to use in immunotherapy versus serum tests (RAST). In allergic bronchopulmonary aspergillosis (ABPA), skin testing with aspergillus allergens is a required diagnostic tool and is a major criterion for the diagnosis of ABPA.

## DIFFERENTIAL DIAGNOSIS

Underdiagnosis of asthma is a common problem particularly among young children who wheeze only with respiratory infections and are diagnosed as having wheezy bronchitis, asthmatic bronchitis, or pneumonia. In children, wheezing and cough also may occur as a result of other causes, including aspiration of a foreign body, a vascular ring, a laryngeal web, tracheal stenosis, laryngotracheomalacia, or enlarged lymph nodes. In general, children who experience three or more separate episodes of bronchospasm are more likely to have asthma. Adults may develop a cough and wheeze as a result of mechanical obstruction, tumors, bronchial carcinoid, laryngeal dysfunction, pulmonary

embolism, pulmonary vasculitis, i.e. Churg-Strauss syndrome, ABPA, emphysema, e.g. alpha-1-antitrypsin deficiency, and cardiac asthma. In the elderly, cardiac asthma, i.e. congestive heart failure, may be confused with asthma in 50 percent of patients.

## CLASSIFICATION

In 1991, the National Heart, Lung and Blood Institute (NHLBI) of the National Institutes of Health issued *Guidelines for the Diagnosis and Management of Asthma* and provided a global plan in 1995. Asthma was classified as mild, moderate, or severe on the basis of symptoms. Patients with wheezing or difficulty in breathing less than two days a week were considered to have mild asthma; patients with wheezing two to five days each week associated with decreased lung function were considered to have moderate asthma; while those patients having continuous symptoms, or frequent exacerbations of symptoms with impaired lung function were considered to have severe asthma.<sup>4</sup>

## TREATMENT GOALS

The National Asthma Education and Prevention Program has established several primary goals for the treatment of asthma, which have been reconfirmed in the international guidelines released in 1992 and the global initiative released in 1995,<sup>5-7</sup> and include: maintenance of near normal pulmonary function; maintenance of normal activity levels (including exercise); prevention of chronic and troublesome symptoms, e.g. coughing or breathlessness in the night, early morning, or after exertion; and avoidance of adverse effects from asthma medications.

## NONPHARMACOLOGIC TREATMENT OF ASTHMA

Asthma and inhalant allergies are clinically linked disorders that

directly benefit from the utilization of self-management programs. A successful educational program focuses on a plan that is jointly developed by the provider and the patient.<sup>8</sup> The program should address the chronic and allergic nature of asthma and empower the patient and family to take an active role in preventing the associated morbidity and mortality. The best plan is based upon objective measurements such as the results of peak flow measurements. Subjective complaints such as the patient's perception of symptoms is clearly not as good as the objective peak flow measurements. Peak flow measurements have been shown to significantly reduce the number of office visits and courses of oral steroids.<sup>9</sup>

Patients with asthma should be tested for allergies, especially dust mites, mold spores, pollens, animal dander, and specific allergens and chemical agents. Control of allergen and irritants (including occupational exposures) that cause asthma is the primary treatment to prevent future exacerbations. In fact, asthma still may progress to become more severe, despite medical care, if the exposure to the triggers are not removed. Immunotherapy may play an extremely important role in asthmatic patients who have well-defined allergic triggers caused by grass pollen, dust mites, animal dander, and *Alternaria* mold allergy. Smoking should be discontinued by the patient and family members since passive exposure to cigarette smoke is as damaging as smoking.

Asthmatic patients should be informed to avoid medications that antagonize the  $\beta_2$ -receptor, including beta blockers used in the treatment of hypertension or glaucoma. In addition, a percentage of asthmatics (less than 10 percent) are sensitive to aspirin and other nonsteroidal anti-inflammatory agents that can exacerbate asthma.



## PHARMACOLOGIC TREATMENT OF ASTHMA

Pharmacotherapy should be based on asthma classification, which is based upon the symptoms and severity of disease. Thus, the two primary therapeutic interventions for asthma are directed at the two major components of asthma—the bronchospasm and the inflammation. It is this greater appreciation of the role of inflammation in the pathogenesis of asthma that has made anti-inflammatory agents of major therapeutic importance in controlling symptoms in all but intermittent asthma. This is in complete contrast to the dominant role previously played by bronchodilators. The step-care approach to therapy is described in the Table.

**$\beta_2$ -agonists.** The primary effect of  $\beta_2$ -agonists is bronchial dilatation, which is achieved through the  $\beta_2$ -adrenoreceptors on the smooth muscle found in the bronchial walls. The use of  $\beta_2$ -agonists is carefully reviewed in the article by Giangrosso in this issue.<sup>10-13</sup>

**Theophylline.** Theophylline is an effective bronchodilator for the treatment of acute asthma, but there are multiple variables to consider prior to utilizing it on a long-term basis. Adverse effects are well documented above the old therapeutic range of 20 ug/ml and experts have recommended the lowering of the therapeutic range from 10 to 20 ug/ml to 5 to 15 ug/ml. Side effects include nausea, diarrhea, vomiting, headache, insomnia, irritability, hyperactivity, tachycardia, arrhythmias, hypoglycemia, convulsions, coma, and circulatory failure. There are multiple drug interactions that either increase or decrease theophylline clearance. Decreased theophylline clearance—increased levels—are due to concurrent therapies such as quinolones and macrolide antibiotics, use of tobacco products, and cimetidine. In addition, diseases

eases that affect the liver's cytochrome P450 enzyme system, including heart failure, will decrease theophylline clearance.

**Anti-inflammatory agents.** Oral corticosteroids have been used for asthma since the 1940s. They prevent the migration and activation of inflammatory immune cells, interfere with the synthesis of bronchospastic prostaglandins and leukotrienes, and increase the bronchial smooth muscle sensitivity to  $\beta_2$ -agonists. Inhaled corticosteroids as well as cromolyn have been found to reduce bronchial hyper-responsiveness to methacholine and allergens.<sup>14,15</sup> The reduction is reversed, however, when the corticosteroids are discontinued.

These agents have been clearly shown to reduce the need for additional bronchodilator agents as well as for oral corticosteroid therapy.<sup>16</sup> Oral corticosteroids given for two weeks have been related to a few immediate side effects (increased appetite, weight gain, rounding of the face, and mood changes). However, long-term high-dose use is associated with multiple problems, e.g. glaucoma, cataracts, osteoporosis, hypertension, avascular necrosis, myopathy, suppressed pituitary function, impaired glucose tolerance. Large immunosuppressive doses of oral corticosteroids also have been associated with fatal varicella infection in children. Side effects associated with inhaled corticosteroids are relatively minor and are primarily associated with oral candidiasis and dysphonia. The use of a spacer can reduce the localized side effects and increase the effectiveness of delivery. The 1995 guidelines on asthma treatment developed by the World Health Organization and NHLBI advocate the regular use of cromolyn or nedocromil early in the treatment of asthma in virtually all patients; and daily use of inhaled corticosteroids in moderate to severe asthma. The inhaled corticosteroids maximize

the therapeutic effect of bronchodilators while having low systemic effects. Intravenous corticosteroids significantly accelerate the resolution of severe asthma symptoms as well as a decrease in the number and length of hospitalizations for asthma, and are not associated with increased mortality.<sup>17,18</sup> In fact, death from asthma is more related to non-use than overuse.

Cromolyn probably is one of the safest agents in the treatment of asthma and, therefore, is recommended for use in children. When given prophylactically on a chronic basis, it inhibits the immediate and late phase allergen-induced bronchospasm. In higher doses, it also inhibits sulfur dioxide-induced asthma; and it reduces bronchial sensitivity to methacholine as well as to specific allergens. It can be nebulized simultaneously with  $\beta_2$ -agonists.

Nedocromil also is considered to be a nonsteroidal anti-inflammatory agent and when administered chronically it reduces bronchial hyper-responsiveness. The most common side effect is the unpleasant taste reported in 10 percent of patients.

Anticholinergic therapy for asthma has been limited due to the adverse effects of older agents, e.g. atropine. However, ipratropium bromide, an atropine derivative, has few adverse effects. Used primarily for the treatment of chronic obstructive pulmonary disease (COPD), its role in the treatment of asthma appears to be limited except for those patients who cannot tolerate inhaled  $\beta_2$  agents. Some studies suggest a positive effect in the treatment of acute asthma in the pediatric population.

## IMMUNOTHERAPY

There is little controversy regarding the role of immunotherapy in the treatment of pollen-induced allergic rhinoconjunctivitis, but such immunotherapy specifically for

**Table. The step-care approach to therapy.**

Asthma type	Clinical features	Acute relief	Chronic control
<b>Intermittent</b>	Symptoms: <1/week Exacerbations: hrs-days Nocturnal: <2/month PFT: normal PEF (or FEV <sub>1</sub> ): ≥80% predicted <20% variability	Short-acting $\beta_2$ -agonist Inhaled as needed <1/week Long-acting $\beta_2$ -agonist or cromolyn prior to exercise or allergen exposure	None
<b>Mild</b>	Symptoms: >1/wk, but <1/day Exacerbations: activity and sleep Nocturnal: >2 month PEF (or FEV <sub>1</sub> ): ≥80% predicted 20-30% variability	Short-acting $\beta_2$ -agonist Inhaled as needed <3-4 ×/day	Inhaled corticosteroid (200-500 $\mu$ g) nedocromil or cromolyn If needed— corticosteroid (500-800 $\mu$ g) long-acting $\beta_2$ -agonist SR theophylline
<b>Moderate</b>	Symptoms: Daily Exacerbations: activity and sleep Nocturnal: >1 week PEF (or FEV <sub>1</sub> ): >60%-<80% predicted >30% variability	Short-acting $\beta_2$ -agonist Inhaled as needed <3-4x/day	Inhaled corticosteroid (800-2,000 $\mu$ g) Long-acting $\beta_2$ -agonist SR theophylline
<b>Severe</b>	Symptoms: Continuous Exacerbations: Frequent Nocturnal: Frequent PEF (or FEV <sub>1</sub> ): ≤60% predicted >30 variability	Short-acting $\beta_2$ -agonist Inhaled as needed	Inhaled corticosteroid (800-2,000 $\mu$ g) and Long-acting $\beta_2$ -agonist SR theophylline and Oral corticosteroids SR theophylline

asthma is under continual investigation. Immunotherapy is considered when avoiding the allergens is not possible and when appropriate medications fail to control symptoms or are not available. Specific immunotherapy has been demonstrated to be effective in asthma caused by grass pollen, dust mites, animal dander, and *Alternaria* mold allergy. The duration of immunotherapy still is unresolved. Overall, a three-year immunotherapy treatment program is the only treatment known to have an effect that lasts for several years. It can be used to treat mild, moderate, and severe asthma.<sup>19</sup> When effective, immunotherapy reduces the needs for other medications. Research presently is ongoing on the de-

velopment allergen vaccines for well-defined allergens, e.g. cat and ragweed allergens, in which the allergens are administered in reduced number of shots when compared to the conventional forms of immunotherapy.

#### STEP-CARE PHARMACOLOGIC THERAPY

Although no cure for asthma has been found, it is reasonable to expect that control of the disease should be able to be maintained in most patients. In the step-care approach to the treatment of asthma, one should be able to achieve the following goals: minimal to no symptoms (including nocturnal); infrequent exacerbations; no emergency visits or hospitalizations; minimal

need for as-needed  $\beta_2$ -agonist; no limitations on physical activity (including exercise); normal peak expiratory effort with a circadian variation of less than 20 percent; and minimal or no adverse effects from medications.

#### MILD ASTHMA

Mild asthma usually is defined by episodes of wheeze or cough (wheeze equivalents) of not more than one or two times a week separated by asymptomatic periods. These patients have excellent exercise tolerance, but may be limited by vigorous aerobic activities lasting more than six minutes. These patients do not have or rarely have nocturnal asthmatic symptoms and their attendance at work or school is



similar to nonasthmatics. Physical examination and pulmonary function results usually are normal. Coughing and wheezing may be induced during forced expiratory breathing. The peak expiratory flow rates and spirometry during attacks are decreased (less than 80 percent of predicted). Methacholine sensitivity is just outside the normal range. These patients can be sustained on bronchodilator agents alone. In many patients with mild asthma, inhaled  $\beta_2$ -agonists may be given on an as needed basis to manage acute symptoms or prevent exercise-induced symptoms.

### MODERATE ASTHMA

Moderate asthma is characterized by a daily or every other day cough or wheeze and nocturnal awakenings more than two to three times a month. Patients will occasionally seek care in an emergency room. The peak expiratory flow rates and spirometry during attacks are decreased 60 to 80 percent of predicted. Methacholine challenge typically results in a 20 percent decrease in  $FEV_1$ . The majority of moderately classified asthmatics will remain moderately impaired while some patients may spontaneously improve and others progress to severe impairment (about 10 percent). It is within the moderate asthma group that anti-inflammatory agents become the mainstay of chronic therapy while the bronchodilators are used to control the intermittent attacks of bronchospasm.

### SEVERE ASTHMA

Severe asthma is characterized by frequent nocturnal awakenings, cough and/or wheeze, and frequent severe exacerbations requiring emergency treatment. Exercise tolerance is low and patients cannot tolerate participating in strenuous activities. Many patients do not perform well in school or at work and have frequent absences and the inability to fully concentrate. Many pa-

tients will have cyanosis, a hyperinflated chest ("barrel chest") with a flattened diaphragm, and substantial wheezing with a rapid expiratory rate. Spirometry shows airway obstruction that is less than 60 percent of predicted. There also may be an element of restrictive disease as evidenced by a decrease in FVC. Unlike the mild to moderate asthma, severe asthma may not be responsive to inhaled bronchodilator therapy. In some patients the reversibility only oc-

curs after initiation of corticosteroids. It is extremely important to monitor peak flow measurement in these patients, to assist the physician-patient treatment program in initiating treatment prior to the patient decompensating. ■

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# Asthma mortality in New Jersey residents

UMDNJ-Asthma & Allergy Research Center

*Researchers at the Asthma & Allergy Research Center noted that from 1972 to 1992, the asthma mortality rate doubled with increased mortality noted in minorities as compared to whites; in females as compared to males; and in individuals over the age of 55 years.*

Though the United States has been seemingly spared the widespread asthma epidemics that plagued Australia, New Zealand, and the United Kingdom during the 1960s, there has been a marked increase in asthma-re-

lated fatalities in the United States over the past 15 years.<sup>1-12</sup> New Jersey is no exception. Vital statistics from the New Jersey State Department of Health (DOH) and the New Jersey State Department of Labor indicate an increase in mortality due to

asthma throughout New Jersey since 1979. An indepth demographic study was conducted of mortality rates due to asthma in all 21 New Jersey counties between the years of 1979 to 1992.

Data collected by DOH and the United States Bureau of Census were analyzed for overall New Jersey asthma mortality, as well as specific makeup of asthma deaths with regard to sex, race, and age from 1979 to 1992.

**Results.** Over the course of 14 years, the total number of reported asthma deaths was 1,368; 973 white and 395 minorities. The overall asthma mortality in New Jersey doubled from 0.8 per 100,000 (n=61) in 1980 to 1.6 per 100,000 (n=121) in 1990 when census data were available (Table 1). Overall racial analyses revealed an increased asthma mortality ratio comparing minorities to the white population (2:1). During this same period, the asthma mortality rate for women compared to men increased. In 1979, 1.0 per 100,000 females in New Jersey died from asthma; in 1990, the rate rose to 2.2 deaths per 100,000 females. Increase in age coincides with a rise in asthma mortality (Table 2). From 1979 to 1992, 63 percent of deaths due to asthma were in people over 55 years. The peak was noted in the 65- to 74-year-old age group. Among the individual counties that were assessed during this study, Essex County had the highest mortality (n=222) (Table 3). The highest

**Table 1. Annual distribution of asthma deaths comparing race and sex between 1979 and 1992.**

Year	White	Minorities	Male	Female
1979	44	17	23	38
1980	39	24	28	35
1981	70	13	30	53
1982	48	17	19	46
1983	64	32	40	56
1984	56	30	29	57
1985	58	31	31	58
1986	66	25	32	59
1987	62	27	32	57
1988	105	37	60	82
1989	82	29	36	74
1990	108	28	50	87
1991	93	42	50	85
1992	78	43	36	85
<b>Total</b>	<b>973</b>	<b>395</b>	<b>496</b>	<b>872</b>

**Table 2. Asthma mortality in different age groups.**

Age	Mortalities 1979-1992	Percentage of mortalities 1979-1992
<1	3	.2
1-4	6	.4
5-14	30	2.2
15-24	66	4.8
25-34	89	6.5
35-44	121	8.9
45-54	191	14.0
55-64	250	18.3
65-74	279	20.4
75-84	222	16.2
>85	111	8.1

**Table 3. Asthma mortality by county from 1979 through 1992.**

County	Mortalities 1979-1992	Percentage of total mortalities
Atlantic	47	3.4
Bergen	134	9.8
Burlington	45	3.3
Camden	92	6.7
Cape May	9	0.7
Cumberland	26	1.9
Essex	222	16.2
Gloucester	32	2.3
Hudson	115	8.4
Hunterdon	10	0.7
Mercer	74	5.4
Middlesex	81	5.9
Monmouth	93	6.8
Morris	50	3.7
Ocean	55	4.0
Passaic	83	6.1
Salem	6	0.4
Somerset	23	1.7
Sussex	21	1.5
Union	128	9.4
Warren	22	1.6

rate of asthma mortality was in Ocean County (age greater than 55 years).

## DISCUSSION

Tabulation of data juxtaposing sex, race, and age versus asthma mortality over the past 14 years indicates a clear evolution of several patterns. Asthmatic fatalities doubled without bias to race, sex, or age. Another interesting point noted is that year by year the number of females killed by asthma is almost double compared to the number of males, and the number of whites is consistently two to three times that of minorities.<sup>3-5</sup>

From 1979 to 1992, Essex County had the largest amount of asthma-related deaths, which coincides with its density of the minority population. Also, from 1979 to 1992, the ratio of male to female deaths remained the same (2:1).

It was determined that minorities are twice as likely to die from asthma as whites. Even though more than two times as many whites than minorities died from asthma-related deaths from 1979 to 1992, the mortality rate of minorities is much greater than whites. In 1979, 0.8 per 100,000 people died from asthma, of which 0.6 were white and 0.2 were minorities. Though the actual number of white people that died was greater, this must be taken in light of the fact that they made up 87.2 percent of the population at that time. Therefore, normalization of the data revealed that in 1980, 1.9 per 100,000 minorities as compared to 0.6 per 100,000 whites died from asthma, clearly marking the increase in the minority mortality rate. Ten years later, in 1990, the minority asthma mortality rate still is much greater than whites and still is on the rise—2.7 per 100,000 minorities as compared to 1.8 per 100,000 whites.

In addition, age clearly coincides with a rise in asthma mortalities.<sup>5,8</sup> From 1979 to 1992,



63.0 percent of deaths due to asthma were in persons over the age of 55 years. As age increases, so does mortality rate from asthma, with the age group of 65 to 74 years at the peak. From 1979 to 1992, 20.4 percent of the asthma deaths occurred in this age group. Only 2.8 percent of the deaths from asthma from 1979 to 1992 can be accounted for by people under the age of 15 years, and a mere 0.6 percent by children up to 5 years old. In each individual year, from 1979 to 1992, the rate of death rises smoothly as the age category increases. This evidence also supports the finding that Ocean County with its large growth in retirement communities has been noted to have the largest increase in mortality rates among all the counties. It is evident that the elderly are far more susceptible to asthma death than the young and middle-aged.

## CONCLUSION

From 1979 to 1992, the rate of death due to asthma in New Jersey doubled from 0.8 per

100,000 to 1.6 per 100,000. The manifested increase in the mortality rate due to asthma is fretful and perplexing especially during times of increased understanding of the pathophysiology of asthma, more effective therapy, and improvements in asthma education.<sup>7,10-12</sup> There is a striking increase in asthma mortality among the sex, race, and age groups for females, minorities, and individuals over the age of 55 years. ■

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# Cost-effective treatment of asthma

Leonard Bielory, MD  
Robert Goldberg, PhD

*Managed care organizations are monitoring asthma to decrease costs relating to health care utilization. Comparisons between primary care providers and asthma specialists reflect better outcomes, treatment programs, and higher patient satisfaction and outcomes for less cost.*

Primary care physicians and specialists treat a variety of chronic disorders. Chronic health care conditions such as cardiovascular diseases, diabetes, and asthma account for a large proportion of the health care dollar spent each year. These conditions also have been singled out by health care agencies for careful monitoring in managed health care environments to reduce health care costs. In recent years, studies have shown that specialists achieve better outcomes, use up-to-date treatment programs, achieve higher patient satisfaction, and achieve better outcomes for less cost. This conclusion has important implications for managed health care programs for asthma and other chronic disorders.

## IMPACT OF ASTHMA

Asthma is a chronic inflammation of the lung airways characterized by shortness of breath and wheezing. Asthma affects over 12 million Americans, including 4 million children. Annually, the disease accounts for 15 million physician visits, 479,000 hospitalizations, 1.2 million emergency room visits, and 10 million missed school or work days.<sup>1</sup>

The economic impact of asthma, estimated at \$6.2 billion a year, can be measured in \$3.6 billion of direct costs such as hospital care, physicians' services, and medications as well as \$2.6 billion in indirect costs each year for lost work days for adults suffering from asthma or caring for children with asthma and lost future earnings from premature deaths associated with asthma.<sup>2-6</sup>

The prevalence of asthma and allergic disorders has continued to increase and, as such, so the direct and indirect costs of asthma have escalated; in addition, there has been an increase in morbidity and mortality. The health care provider and the medical director in the managed care organization must determine the most effective, as well as economical, methods of treatment.

## TREATMENT OUTCOMES

Asthma is a chronic disease that absorbs at least 1 percent of the annual health care dollar. If not managed properly, asthma can result in hospitalizations, emergency room visits, and missed work and school days. Recent studies have shown that patients who receive treatment from asthma specialists who care for both chil-

dren and adult patients experience better outcomes, including: decrease in hospitalizations; reduction in the length of hospital stays; decrease in emergency room visits; decrease in number of sick care office visits; decrease in missed work or school; increase in productivity; and increase in satisfaction with care and disease management.

Asthma specialists are defined as health care providers who have received cross training in adult and pediatric asthma such as an allergist who is conjointly trained in adult and pediatric asthma and allergic and immunologic disorders or an adult pulmonologist who has received additional training in pediatric asthma or a pediatric pulmonologist who has received additional training in adult asthma.

**Hospitalizations.** Asthma causes 479,000 hospital admissions annually with a national average length of stay of 5.4 days. The cost of hospitalizations, the single largest direct medical expenditure for asthma, is estimated at \$1.6 billion annually. Since the inception of New Jersey's diagnosis related groups (DRGs), New Jersey's length of stay for asthma has decreased to 4.8 days (1992 to 1993 data). Studies have shown that referral to an asthma specialist, such as an allergist, has been associated with decreased hospitalizations and lengths of stay due to aggressive asthma management and treatment when compared to those patients treat-

ed by family physicians and pediatricians.<sup>7</sup> As an example, hospital admissions decreased 68 percent, and the average length of hospital stay declined from 4 days to 2.5 days in an evaluation of outcomes for moderate to severe asthma patients treated by a specialist.<sup>8</sup> A 1993 retrospective study found that only 13 percent of the patients who received followup care by an asthma specialist after hospitalization were hospitalized again compared to 35 percent of the patients treated by a non-asthma specialist.<sup>9</sup>

In a study of intubated asthma patients, an aggressive intervention program that included education, regular outpatient visits, and access to emergency call service significantly reduced the number of inpatient hospitalizations.<sup>10</sup> This study showed a savings in direct costs per patient from \$2,477 to \$34,641.

**Emergency room visits.** Emergency room visits for asthma patients result in health care expenditures of \$295 million annually. The frequency of visits to an emergency room can be reduced for patients under the care of an asthma specialist, with an accompanying cost savings of 49 percent. A study of a Kaiser Health Plan in San Diego compared treatment outcomes for patients who came to the emergency room with acute asthma symptoms. Patients who were referred to asthma specialists experienced 50 percent fewer asthma relapses requiring an emergency room visit compared to patients who continued to be treated by a primary care physician.<sup>11</sup>

Studies also have confirmed a decrease in emergency room visits when patients were treated by an asthma specialist. Specific comparisons include: a 56 percent decrease in emergency room visits for moderate to severe asthmatics after referral to an asthma specialist; 18 percent of asthma specialist patients requiring emergency room visits compared to 47 percent of patients

treated by non-asthma specialists; a decrease from four emergency room visits per year to none following short-term inpatient rehabilitation; a 76 percent decrease in emergency room visits after treatment at an asthma center; a 65.9 percent reduction in emergency room visits after the introduction of nedocromil sodium, often prescribed in aggressive asthma therapy.<sup>12-14</sup>

**Sick care office visits.** Health care utilization also is measured by office visits. Asthma is associated with 15 million annual office visits to physicians. Of these, approximately 35 percent are patients under the age of 20 years. Although the majority of asthma care is given by physicians practicing in the primary care specialties of family medicine, pediatrics, and internal medicine, care by an asthma specialist typically reduces the number of sick care office visits. A retrospective study of moderate to severe asthma patients treated in a Kaiser Permanente health plan in Denver found sick care office visits reduced by 46 percent in asthma patients who received followup care by a specialist for at least one year.

**Missed work/school days.** Aggressive asthma management and treatment by an asthma specialist can reduce missed work and school days. One study found that patients who are treated by a specialist have one-half as many lost work and school days.<sup>15</sup> The financial loss of lost work days for parents caring for children with asthma is estimated at \$900 million a year and the financial loss for adults who lost work days is estimated to be \$846 million per year. The potential savings are enormous. Another study found that patients who were involved in a comprehensive home and ambulatory program for pediatric asthma management missed 10.7 school days compared to 16 missed school days for the control group.<sup>16</sup> The use of nedocromil sodium also has been

found to decrease the number of missed work and school days.<sup>17</sup>

## SUMMARY

Aggressive management and treatment of asthma by an asthma specialist produces better outcomes and reduces the costs of the disease. One recent study projects the annual national savings to be \$1.3 billion if all asthma patients were treated by allergists or at asthma centers. Although some research suggests that patients of asthma specialists have higher costs for prescription drugs, including medications and allergy shots, these are more than offset by better outcomes and overall savings resulting from fewer hospitalizations, fewer emergency room visits, and less lost work or school days. In addition, patients who received asthma care from an asthma specialist experienced improved activity levels and better emotional functioning between asthma attacks, which also is reflected in these patients being more satisfied with their physicians and their medical care in general. ■

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# Prudent use of $\beta_2$ -agonists in the treatment of asthma

Thomas Giangrosso, MD

*The primary disorder in asthma is airway inflammation, which must be managed with anti-inflammatory agents. A review of recent literature highlights conflicting perspectives of the comparative efficacy and safety of short- and long-acting  $\beta_2$ -agonists and their very different roles in asthma therapy.*

For over 30 years  $\beta_2$ -agonists have been used as first-line therapy for relief of asthma symptoms. However, increases in the morbidity and mortality of the disease allegedly associated with these agents, together with a revision in understanding of asthma pathophysiology, have led to a re-examination of their role in asthma therapy.

Regular or exclusive use of long- or short-acting  $\beta_2$ -agonists for management of chronic asthma is considered to be inappropriate and potentially dangerous by some authorities. However, authorities agree that there is a continuing need for  $\beta_2$ -agonists on an as-needed (PRN) basis, and even on a more extensive basis if they are used in tandem with corticosteroids or other anti-inflammatory agents for severe asthma. Short-acting  $\beta_2$ -agonists will have a continuing presence in asthma therapeutics because they are uniquely suited for rescue therapy, rapid relief of symptoms, and specific prophylactic tasks. Their relatively short duration of action offers an opportunity for a more flexible approach to asthma management for patients with mild disease, and

they can be used with corticosteroids and long-acting  $\beta_2$ -agonists for patients with severe asthma. Even when prescribed a long-acting  $\beta_2$ -agonist, patients also must have a short-acting agent such as albuterol prescribed for rapid relief of acute asthma symptoms.

## PHARMACOLOGIC TREATMENT

The National Heart, Lung and Blood Institute recommends using inhaled, short-acting  $\beta_2$ -agonists as needed for patients with mild asthma characterized by acute, intermittent, and brief symptoms less than one to two times a week, nocturnal symptoms less than two times a month, and no symptoms at all other times. No additional asthma therapy is required for this subpopulation. Use of short-acting  $\beta_2$ -agonists also is suggested for pretreatment of exercise-induced asthma. Long-acting  $\beta_2$ -agonist therapy is recommended for those with moderate to severe disease (in tandem with daily inhaled anti-inflammatory therapy) and when treatment for nocturnal symptoms is required.

**Pharmacologic-pharmacodynamic profiles.** Long-acting

(salmeterol and formoterol) and short-acting (isoprenaline, albuterol, terbutaline, bitolterol, pirbuterol, metaproterenol, and fenoterol)  $\beta$ -adrenoreceptor agonists differ chemically and kinetically. Both groups are selective for the  $\beta_2$ -receptors; albuterol, however, is the most  $\beta_2$  specific, which minimizes its potential for side effects. Salmeterol and formoterol are highly lipophilic and more slowly absorbed. Of the short-acting agents, fenoterol and isoprenaline have greater cardiac  $\beta$ -receptor potency; and salmeterol is up to 17.7 times more potent for cardiac effects than albuterol, as evidenced by increased heart rates and decreased plasma potassium concentrations.<sup>2</sup> Chemical and metabolic differences account for differing pharmacodynamic and safety profiles.

**Efficacy.** Pearlman compared 42  $\mu$ g inhaled salmeterol administered twice daily with 180  $\mu$ g inhaled albuterol administered four times daily for 12 weeks to patients with mild to moderate asthma.<sup>3</sup> The results showed salmeterol was significantly more effective than albuterol only on day one and at week 4 of the study, but not at weeks 8 or 12, although salmeterol has a bronchodilator effect 10 times greater than that of albuterol and a much higher  $\beta_2/\beta_1$  selectivity ratio (50,000:1 versus 650:1). The differences in the treatment benefit in this and other studies



is related to duration of effect. Short-acting  $\beta_2$ -agonist therapy has proved effective for the prophylaxis of exercise-induced asthma. Patients treated with a long-acting  $\beta_2$ -agonist for protection against exercise-induced symptoms must take the medication at least 30 to 60 minutes before they begin to exercise, which may make it impractical for early morning or unplanned exercise; short-acting agents such as albuterol are taken 15 minutes before exercise.

Clinically, the pharmacodynamic differences between long- and short-acting  $\beta_2$ -agonists support the use of short-acting agents for treatment of acute bronchoconstriction, as rescue medication, and for prophylaxis of exercise-induced wheezing. The place of long-acting  $\beta_2$ -agonists is less certain. Some investigators suggest their suitability for treatment of nocturnal asthma.<sup>4</sup> However, the long duration of action of these agents can mask asthma progression and may encourage exacerbations from inhaled allergens. Their safety profile, which is directly related to their efficacy, is a matter of concern, particularly with regard to tolerance or sudden loss of efficacy with regular use.<sup>5-8</sup> This is a subject of continuing discussion. Most experts agree that regular therapy with short- or long-acting  $\beta_2$ -agonists cannot reverse the disease process or provide long-lasting symptom control.

While there is general agreement about the superior duration of action of the new long-acting  $\beta_2$ -agonists, there are conflicting data about their long-term efficacy when in regular use. Some trials have demonstrated diminishing bronchodilatory effects after four and eight weeks of regular treatment,<sup>8</sup> while others show no such results after one year. Sears showed that regular inhalation of  $\beta_2$ -agonists over a six-month period led to loss of asthma control by maintaining or increasing airway lability or by

providing partial control of symptoms, masking worsening disease.<sup>9</sup> Uncertainty has led cautious experts to advise against long-term monotherapy with  $\beta_2$ -agonists and to recommend their use only in tandem with inhaled corticosteroids, or, in more severe cases, with oral steroid therapy.

**Safety.** The safety of  $\beta_2$ -agonists is a subject of continuing controversy. Are the class of drugs, the dose levels, the dose regimens, or specific drugs within

near deaths in many countries have been associated with regular use of  $\beta_2$ -agonists. Masking of worsening disease leading to loss of asthma control is another serious concern associated with regular use of these agents, and increasing use is considered to be a sign of worsening disease. Rapid cessation of treatment with  $\beta_2$ -agonists has been shown to increase patient vulnerability to exogenous constrictor stimuli and nocturnal symptoms.

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*Short-acting  $\beta_2$ -agonists are ideally suited for PRN use for all levels of asthma severity, to relieve symptoms, or for prophylaxis against exercise-induced bronchoconstriction. They also may be used as monotherapy PRN for mild asthma.*

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the class associated with the increasing morbidity and mortality of asthma? Can patients become tolerant to the effects of  $\beta_2$ -agonists with regular use?

**Deterioration of asthma control.** Sears and van Schayck demonstrated deterioration in asthma control with regular use of  $\beta_2$ -agonists, with Sears presenting persuasive evidence that the increased use of inhaled high-dose fenoterol and isoprenaline could be the only source for the epidemics of asthma deaths in New Zealand, England, and Wales.<sup>9,10</sup> They cited numerous instances of loss of asthma control in other studies incorporating regular use of inhaled  $\beta_2$ -agonists, and ruled out the delivery system and lack of anti-inflammatory therapy as causative factors for the loss of asthma control.

**Tolerance/tachyphylaxis.** Regular use of even low-dose  $\beta_2$ -agonists over a few weeks can cause airways hyper-responsiveness, increased bronchial reactivity,<sup>11</sup> and tolerance to their acute protective effects against bronchoconstriction.<sup>12</sup> Decreasing sensitivity of  $\beta$ -adrenoreceptors<sup>13</sup> and increasing episodes of respiratory arrest, deaths, and

**Adverse effects.** In a study comparing inhaled salmeterol at doses of 12.5, 25, 50, and 100  $\mu$ g with albuterol aerosol 200  $\mu$ g and matching placebo delivered once daily to young adults with mild to moderate asthma, Holter monitoring showed that the mean maximum heart rate and the incidence of high-frequency supraventricular premature beats were higher after administration of 50 and 100  $\mu$ g salmeterol than after administration of 200  $\mu$ g albuterol.<sup>14</sup> Clinical adverse events reported as possibly drug related also increased with increasing doses of salmeterol from 25  $\mu$ g to 100  $\mu$ g. The incidence of tremor increased from 4 to 21 percent in the salmeterol group, and headache from 4 to 17 percent. The incidence of palpitations also was 17 percent at the 100  $\mu$ g dose. All other adverse events, i.e. diarrhea, nausea, hyperactivity, were at 4 percent each at the 100  $\mu$ g dose. In contrast, in the albuterol group the incidence of tremor, diarrhea, and hyperactivity was 4 percent, with no headaches or

**Death or near death.** In a large, matched case control study, Spitzer concluded that episodes



of death and near-death from asthma in Saskatchewan, Canada were related to the dose of regularly used inhaled  $\beta_2$ -agonists, particularly fenoterol.<sup>15</sup>

Crane, commenting about the relationship of  $\beta$ -agonist treatment to epidemics of asthma-related deaths, pointed to the pharmacologic differences between  $\beta$ -agonists such as fenoterol and isoprenaline and others such as albuterol and terbutaline, which have not been directly associated with such episodes.<sup>16</sup> Fenoterol and isoprenaline have greater cardiac  $\beta$ -receptor potency and less  $\beta_2$  selectivity than albuterol and terbutaline, accounting for their greater adverse cardiovascular effects when repeatedly inhaled.

Castle reported the results of a nationwide postmarketing surveillance study of salmeterol compared with albuterol in a cohort of 25,180 patients requiring regular bronchodilator treatment.<sup>6</sup> These patients received 50  $\mu$ g salmeterol twice daily or 200  $\mu$ g albuterol four times daily for 16 weeks. Results of the study showed a nonsignificant excess mortality in the group taking salmeterol but a significant excess of asthma events, including deaths, in patients with severe asthma on study entry. While Castle suggested that these adverse events were related to undertreatment, they recognized that patients with severe or unstable asthma are at risk and should not be treated with high doses of  $\beta_2$ -agonists as monotherapy.

Sears compared the mortality in the Castle study with that of the general population in England and Wales (the sites of the Castle study) from 1988 to 1990, noting that 50 percent of the patients in the study who were treated with salmeterol and who died were under age 50, compared with only 18 percent of patients in the general population, and 75 percent were under age 65 in the salmeterol study, compared with 39 percent in the

national statistics. These figures led Sears to speculate that salmeterol treatment may increase the risk of death in the younger patient population, a supposition that was supported by the findings of Clark, who reported three case histories of respiratory arrests in young asthmatics, each of whom had recently begun treatment with salmeterol.

Recent reports of deaths attributable to respiratory arrest in patients after the use of inhaled salmeterol emphasize the importance of appropriate use of  $\beta_2$ -agonists.<sup>19,20</sup> In these cases, it was not possible to determine whether salmeterol contributed to respiratory arrest or simply failed to relieve worsening asthma, while masking symptoms. Revisions in the drug's labeling caution that salmeterol should not be initiated in patients with worsening or acutely deteriorating asthma.<sup>21</sup> Further, it was stated that salmeterol should not be used for rescue situations; rather, a short-acting  $\beta_2$ -agonist should be used for that purpose.

**Economic considerations.** Pharmacoeconomic considerations play an increasingly important role in selection of drug therapy. Long-acting  $\beta_2$ -agonists such as salmeterol are more expensive than short-acting agents such as albuterol. Unlike albuterol, which should be administered PRN, salmeterol requires twice-daily administration for the duration of therapy. The average wholesale price for a 120-dose salmeterol metered dose inhaler is 33 cents/puff, compared with 9.5 cents/puff for inhaled albuterol, a difference that becomes significant when the dosing regimen is taken into account. Based on the recommended four puffs daily, the average daily cost for salmeterol is \$1.32, compared with eight puffs of albuterol at \$.76 a day. When the medication is used PRN as recommended, the average daily cost of albuterol would be even lower than \$.76.

## CONCLUSION

Prudent use of  $\beta_2$ -agonists is guided by the knowledge that the primary disorder in asthma is airway inflammation, which must be managed with regular use of anti-inflammatory agents such as inhaled corticosteroids, sodium cromoglycate, or nedocromil sodium. For this reason, and because of safety concerns,  $\beta_2$ -agonists no longer are recommended for regular maintenance therapy of asthma.<sup>22</sup>

Short-acting  $\beta_2$ -agonists are ideally suited for PRN use for all levels of asthma severity, to relieve acute symptoms, or for prophylaxis against exercise-induced bronchoconstriction. They also may be used as monotherapy PRN for mild asthma. Long-acting  $\beta_2$ -agonists should be used only in the treatment of moderate to severe asthma when symptoms are poorly controlled despite regular use of high-dose inhaled corticosteroids and intermittent use of short-acting  $\beta_2$ -agonists, but should not be initiated in patients with worsening or deteriorating asthma. Long-acting  $\beta_2$ -agonists should not be used without short-acting  $\beta_2$ -agonists for relief of acute symptoms, or when symptoms are controlled with short-acting  $\beta_2$ -agonists. ■

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# Asthma: The inner-city problem in New Jersey

UMDNJ-Asthma & Allergy  
Research Center

*There continues to be difficulties with asthma management. Significant concerns about morbidity and mortality persist, particularly in minority, lower-income populations, living in urban areas. Patients in urban areas and lower-income groups are less likely to have access to comprehensive treatment.*

Asthma affects millions of Americans, with over 6.2 billion dollars spent yearly in the United States for medical treatment of this chronic disease.<sup>1</sup> Derived from the second National Health and Nutrition Examination Survey (NHANES II), data indicate that in 1987, 25 million persons in the United States currently had, or once had, asthma.<sup>2-4</sup> The prevalence of active asthma is estimated at 7.7 percent of the population of the United States, or approximately 17.5 million people. Data from the National Health Interview Survey (NHIS) indicate that the prevalence of asthma in children under 18 years of age has increased from 3.2 percent in 1981 to 4.3 percent in 1988, with an estimated 2.7 million children under 18 years of age reported to have active asthma.<sup>5</sup> Overall, individuals with asthma experience more than 100 million days of restricted activity annually.

Asthma, in school-aged children, leads to 10.1 million days of school absenteeism, 12.9 million contacts with medical doctors, and 200,000 hospitalizations annually.<sup>5</sup> Data indicate that morbidity associated with asthma is

highest among inner-city minority populations, particularly African-Americans. In a Michigan-based study, the prevalence of asthma-related hospitalizations in children ages 10 to 14 years increased from 2.2 per 1,000 in 1980 to 3.2 per 1,000 in 1984; whereas the prevalence for African-American children increased from 3.2 per 1,000 in 1980 to 7.1 per 1,000 in 1984.

In addition to the increasing morbidity, there is alarming data over the last decade that suggest a statistically significant increase in the number of deaths from asthma. This increase has been seen in all population groups, but particularly is significant in inner-city, African-American asthmatic patients.<sup>6</sup> Nationally, the death rate secondary to asthma for whites increased from 1.1 per 100,000 persons in 1979 to 1.4 in 1984; while for African-Americans the rate increased from 1.8 to 2.5, respectively.<sup>7,8</sup>

Asthma continues to be a significant public health problem.<sup>9-12</sup> An example of an urbanized problem associated with asthma comes from data compiled by the Asthma & Allergy Research Center at UMDNJ-New Jersey Medical School based on

records of New Jersey State Department of Health (DOH) death certificates; data indicate that the number of asthma deaths in the state have more than doubled, from 63 in 1980 to 137 in 1990.<sup>13</sup> This increase over a ten-year period is not explained by population growth, since the census during this period only increased by 5 percent, from 7,364,823 to 7,730,188. In Newark, the largest city in New Jersey, deaths from asthma have risen from 10 in 1979 to 23 in 1992, while the population has declined by 8.5 percent from 1980 to 1990. Within the county in which Newark is located, there is a difference in asthma morbidity and mortality between the predominantly poor, minority populations of the inner-city of Newark, and the middle and upper-middle class population of the suburban parts of the county. This is reflected by the normalized asthma deaths in Newark of 5.8 deaths per 100,000 as compared to the remainder of the county (excluding Newark) of 2.8 deaths per 100,000. Similarly, data on hospital admissions reveal that the hospital admission rate with a diagnosis of asthma was 110 patients per 100,000 for Newark, but only 46 patients for the remainder of the county. Some investigators have suggested that inner-city African-American asthmatics tend to utilize hospital emergency services rather than primary care physicians for routine asthma manage-

ment. Additionally, they also may delay seeking medical attention until symptoms are severe, and, consequently, incur more asthma-related hospitalizations.

These differences, based on ethnic and socioeconomic status, have been described elsewhere in the United States. A study at Hahnemann University in Philadelphia compared two geographic areas of the city with different annual rates of asthma mortality: one area with a mortality rate of 0.38 persons per 100,000 and the other area with a mortality rate of 6.66 persons per 100,000. The higher asthma mortality area had a higher rate of poverty (47 percent) and an ethnic makeup of predominantly minority populations, i.e. 79 percent African-American, 10 percent Hispanic, and 11 percent white.

The reasons for these differences in asthma-related morbidity and mortality between urban and suburban populations and, of varying socioeconomic stature, is not known with certainty. Some authors speculate that the lack of access to high-quality health care, or the failure of physicians to follow National Institutes of Health (NIH) guidelines in the inner city, may account for this finding. In addition, poor, inner-city populations may be more likely to be exposed to environmental triggers because of crowded and difficult living conditions.

Adherence to the NIH *Guidelines for the Diagnosis and Management of Asthma*, particularly through the use of anti-inflammatory medications, may reverse the trend of increasing asthma morbidity and mortality. According to data from the National Center for Health Statistics, rates of death from asthma may be stabilizing coincident with increasing sales of cromolyn sodium and inhaled corticosteroids. According to the report, rates of death from asthma in the United States increased from 0.8 per 100,000 in 1977 to 2.0 in 1989,

and then decreased slightly to 1.9 per 100,000 in 1990. Rates of death for 5 to 34 year olds increased from 0.26 per 100,000 in 1980, to 0.42 in 1987 and 1988, and 0.43 in 1989 and 1990. Estimated sales of cromolyn have increased from 0.047 doses per person in 1978, to 0.91 in 1991, and that of inhaled corticosteroids increased from 0.44 puffs per person in the general population in 1976, to 5.44 puffs per person in 1991. In areas with higher use of inhaled steroids and a lower bronchodilator/inhaled steroid ratio, suggesting better adherence to the NIH asthma guidelines, there was a lower death rate, lower rate of poverty (7 percent), and an ethnic makeup of 97 percent white, 1 percent African-American, and 2 percent Hispanic.

For at-risk, inner-city populations, outcomes can be improved by prescribing appropriate drugs. Michigan Medicaid data from 1980 to 1986 were examined for asthma drug treatment among low-income children 5 to 14 years of age. Higher percentages of poor, black, urban children were found to receive inadequate and outmoded drug therapy, long after use of these therapies in other groups of Medicaid patients decreased. However, variations in asthma treatment exist despite equivalent Medicaid coverage that also looked at prescription practices as an outcome assessment.<sup>14</sup> Four drug groups were evaluated: adrenergics, bronchodilators, systemic steroids, and fixed-combination products (drugs containing a bronchodilator, an adrenergic, a sedative, and occasionally an expectorant). It was found that a much larger percentage of urban black patients received fixed-combination products long after their white, urban, and black and white rural counterparts had been switched to more effective and appropriate therapy. Black children also received fewer steroids than other children. In recent years, the ap-

propriate use of steroids and other anti-inflammatory medications now is believed to improve asthma outcomes.

It was not until 1984, when Medicaid stopped reimbursement for nearly all fixed-combination asthma products, that urban physicians adopted more effective therapy for African-American asthmatic children. Researchers suggest several possible explanations, including patient product preference, physician convenience of prescribing one versus multiple medications, or the lack of physician education.

Similarly, in the Newark metropolitan area, the monitoring of asthma medication sales, including theophylline, have remained unchanged since the inception of the NIH *Guidelines for the Diagnosis and Management of Asthma*. In fact, northern New Jersey and the New York/Staten Island regions have the largest sales of bronchodilators including theophylline in the country. There has been no increase in the use of anti-inflammatory medications for asthma in the Newark population. This supports other investigators' findings that the guidelines, which reflect the importance of treating the inflammatory aspect of asthma, have not been incorporated into the actual practice of inner-city primary care physicians.

NIH, through a variety of initiatives, is continuing to analyze the asthma problem within the inner city and to develop several possible interventions (Table).

The National Institute of Allergy and Infectious Diseases (NIAID) developed the National Cooperative Inner-City Asthma Study (NCICAS) Phase I, which was initiated in 1991 and is planned for completion in 1996. The preliminary results of NCICAS Phase I, presented at the NIH Asthma Workshop in May 1995, identified factors amenable to intervention that determine asthma severity and morbidity among inner-city



**Table. Comparison of various asthma education programs and their impact on health care dollars.**

Number of patients in the trial program designed for the number of nursing contact hours results					
Year	Program	No. of patients	Program designed for	No. of Nursing contact hours	Results
1980	Teaching Myself About Asthma (Health Education Associates)	53	Children	16	No change in ER visits/hospitalizations
1981	Winning Over Wheezing (Dr. Rusnack)	?	Children	?	?
1981	Superstuff (American Lung Assn.)	?	Children	?	No decrease in ER visits or hospitalizations
1983	Living with Asthma (NHLBI, Ohio University)	147	Children	8	80 percent decrease in number of attacks/month
1984	Asthma Care Training (ACT) (UCLA)	76	Children	5	Cost savings of \$180/child/year
1984	Air Power/Air Wise (NHLBI)	4	Children	5	Cost savings of \$507/child/year
1984	Family Asthma Program (Dr. Hindi-Alexander)	92	Children	12	No decrease in ER visits or hospitalizations
1985	Self-Care Rehabilitation Program (American Lung Assn. of Utah)	59	Children	9	Decrease in asthma episodes
1986	Open Airways (NHLBI)	207	Children	7	Saved \$11.22 for each \$1 spent
1990	UAB Self-Management Program (Univ. Alabama at Birmingham)	124	Adults	1	Decrease in ER visits by 70 percent but control group decreased by 68 percent (just secondary to followups?)
1991	Southeast Kaiser Permanente	1,850	Children and adults	0	\$1 million saved in decreased hospitalization costs over just the first year of the program; 30 percent decrease in the number of hospitalizations

asthmatic children, including access to medical care, poor self-management, and environmental exposures.

Environmental contaminants may play a larger role in asthma exacerbations than previously appreciated. Over 150,000,000 Americans live in communities where the ambient levels of ozone exceeds the allowable health-based National Ambient Air Quality Standard (NAAQS) of 0.12 ppm. Ozone, an intense irri-

tant, has been shown to produce bronchoconstriction in controlled human exposures through an inflammatory response of the bronchioles similar to allergen-induced bronchiole inflammation.<sup>15-17</sup> Ozone also has been associated with increased frequency of asthma visits to hospital emergency room departments.<sup>18,19</sup> Nitrogen dioxide has been reported to have no correlation with asthma morbidity, but a recent article in *Lancet* leads one to

rethink the design for possible NO<sub>2</sub> exposure. In addition, environmental tobacco smoke has been shown to be associated with a significant decline in pulmonary function in one-third of smoke sensitive asthmatics.<sup>20</sup> All of these "pollutants" seem to act as adjuvants to the common allergens found in urbanized centers.

It has become apparent that an educational program focused on the patient and family and the primary care physician can have

a tremendous impact on the improvement of asthma outcomes. Many managed care programs wish to incorporate educational intervention programs into protocols since they acknowledge that asthma consumes 1 percent of their total health costs; they also recognize this is an area that can have the greatest fiscal impact in savings.

The NIAID NCICAS Phase II objective is the development of an educational intervention trial using, as an example, an asthma counselor with a social work background to modify the factors identified to further reduce asthma in these populations. The primary focus still is on the underserved urban asthmatic children and adolescents (ages 4 to 12 years).

NIAID also has established the Asthma, Allergy, and Immunologic Diseases Cooperative Research Centers (AAIDCRCs) to promote an interaction between scientists and clinical researchers to further enhance outreach and demonstration projects. These centers study fundamental immunological concepts as they relate to biochemistry, genetics, and pharmacology.

Remarkable advances have been made over the past 15 years in the basic understanding of asthma; morbidity and mortality rates in the United States have continued to increase, particularly in minority populations. Research into the plausible interventions in the inner-city population will undoubtedly provide a better understanding to meet the challenge of improving the diagnosis and treatment of asthma for everyone. ■

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# Inhaled steroids in the treatment of asthma

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*The authors present a review of recent data that is relevant to the effects of inhaled steroids on the bone growth of asthma patients. The authors recommend appropriate treatment plans based on this review and the NHBLI/NIH guidelines for the management of asthma.*

Corticosteroids have been used for many years in the management of asthma. Although extremely effective, orally administered corticosteroids are associated with adverse effects. The finding that long-term treatment with oral corticosteroids may cause growth impairment in children is of particular concern.<sup>1</sup> In the 1970s, inhaled corticosteroids were introduced and expected to be free from the systemic side effects seen with oral corticosteroids. Subsequently, reports suggestive of systemic effects have appeared in the medical literature raising questions about the relative safety of this class of medication.<sup>1-4</sup> This review presents the data relevant to the effects of inhaled steroids on bone growth and recommends appropriate treatment plans based on this information. This review is important in view of the recent NHBLI/NIH guidelines for the management of asthma, which recommend increased use of anti-inflammatory agents (including inhaled steroids) as first-line therapy for asthma.<sup>1,2</sup>

## GROWTH IN CHILDREN

The effect of inhaled cor-

ticosteroids on growth for children with asthma is difficult to ascertain since severe asthma can have a growth-retarding effect that is independent of therapy.<sup>5-6</sup> One study suggests that in severe asthma, long-term treatment with inhaled steroids does not adversely affect growth.<sup>8</sup> In fact, there is some evidence that inhaled steroids, by bringing severe asthma under control, may actually allow catch-up growth in some children.<sup>7</sup>

In recent years, some physicians have recommended that even mild and moderate asthma be treated with inhaled steroids.<sup>9</sup> In this group of patients, one might expect the growth-retarding effects of a chronic disease to be less pronounced, and any growth-inhibiting effect of inhaled steroids to be more readily observed. In fact, several researchers detected decreased growth in mild-to-moderate asthmatics treated with inhaled steroids. The American Academy of Allergy, Asthma and Immunology Study Group conducted a study of 195 children between the ages of 6 and 16 years with mild-to-moderate asthma. Treatment with a relatively low dose (400 mcg/daily) of the

inhaled corticosteroid, beclomethasone dipropionate (BDP), for one year resulted in growth velocity suppression equivalent to 1.6 cm in height compared with a control group with equally severe asthma.<sup>9</sup> A British group determined the effect of BDP and budesonide on growth, linear growth velocity, and the growth hormone axis on 56 prepubertal asthmatic children over one year in a controlled fashion.<sup>10</sup> Growth velocity in the nonsteroid treated control group (n=13) was normal. Ten of 20 children taking BDP, 4 of 19 children taking budesonide, and 3 of 4 children using an inhaled steroid plus prednisolone grew slowly. Interestingly, growth hormone secretion measured normal in all of the treatment groups.

A British study of 162 asthmatic children tracked height over a nine-month period and found BDP caused a significant reduction in growth velocity.<sup>11</sup> Another seven-month British study followed 104 children ages seven to nine years with mild-to-moderate asthma, either on a relatively low dose of BDP (400 mcg/day) or placebo. Height was measured at least monthly and at least twice a month for five months after the inhaled steroid (or placebo) was stopped. At the end of the seven-month treatment phase, the mean growth was 0.95 cm greater in the placebo group versus the inhaled steroid group. Extrapolated to one year, this is the same figure as reported in the

United States study cited above. At the end of the five-month "wash-out" period, there still was a 0.8 cm difference between the steroid and control groups indicating little catch-up growth.

These results may be cause for some concern, especially since they are supported by data from knemometry studies, a device that precisely measures the length of the lower leg. Such studies have repeatedly shown a significant reduction of the growth velocity of the lower leg over periods ranging from 18 days to 12 weeks in children taking low to moderate doses of inhaled steroids.<sup>13-16</sup> Prior to the publication of studies such as the one performed by the Academy of Allergy, Asthma and Immunology, these results have been largely dismissed as clinically irrelevant, but now have to be reassessed.

Growth retardation from inhaled steroids probably affects only a subpopulation of asthmatic children who are exquisitely sensitive to suppression by corticosteroids. This hypothesis is supported by several case reports where patients demonstrated severe susceptibility to the growth suppressive effects of inhaled steroids, usually not seen in others. Examples include the following:

- An eight-year-old asthmatic girl treated for ten months with the inhaled triamcinolone, at a daily dose within the normal range, developed weight gain, hirsutism, and growth retardation. These side effects resolved when the steroid was stopped.<sup>17</sup>

- Six asthmatic children developed growth failure during treatment with the inhaled steroid, beclomethasone.<sup>4</sup>

- Reports of idiosyncratic responses occurred in some children taking inhaled corticosteroids, resulting in significant growth suppression.<sup>18-19</sup>

Potential implications of these various studies and reports of the effects of inhaled steroids on

growth must be considered. The data support the propensity of inhaled steroids to slow growth when used to treat mild asthma. However, the reduction in height is an average number for entire groups of children. Because children have individual responses to steroids, this means that inhaled steroids will have an effect greater than the group mean in some children, a lesser effect in others, and no effect at all in the remainder. Unfortunately, there is no method of predicting the growth response to inhaled steroids for an individual child.

The prudent approach for physicians treating the mild-to-moderate asthmatic child would be a trial of nonsteroidal anti-inflammatory agents prior to inhaled steroids. If asthmatic symptoms are inadequately controlled with inhaled cromolyn sodium or nedocromil, then use of inhaled steroids is appropriate. This approach is supported by the Food and Drug Administration (FDA), which recommends a trial of a nonsteroid anti-asthma medication before steroids, whether oral or inhaled.

In more severe asthma, there are no long-term, controlled studies that indicate that inhaled steroids adversely affect growth. This does not rule out the occasional idiosyncratic response from a child who is unusually sensitive to the steroid. This problem could be less common or even nonexistent (except perhaps at high doses) with some of the newer inhaled steroids not yet available in the United States. Long-term studies will need to be conducted with these newer drugs. There is no evidence from long-term studies in children with mild or mild-to-moderate asthma who experience growth suppression that catch-up growth will occur later in life. One study in more severe asthmatics suggested that this does occur. Clearly, more research is needed in children with mild asthma.

## CONCLUSION

The following rational conclusions can be derived from the reported studies and individual case reports.

1. Growth suppression has been shown to occur in some children with mild-to-moderate asthma. For unknown reasons, it does not seem to occur with the use of inhaled steroids in severe asthma.

2. Recognizing that inhaled corticosteroids are effective, even life-saving, they should be used according to FDA-approved indications, which state: "Only for patients who require chronic treatment with corticosteroids for control of the symptoms of bronchial asthma. Such patients would include those already receiving systemic corticosteroids and selected patients who are inadequately controlled on a nonsteroid regimen and in whom steroid therapy has been withheld because of concern over potential adverse effects. Inhaled corticosteroids are not indicated: for relief of asthma that can be controlled by bronchodilator and other nonsteroid medications; in patients who require systemic corticosteroid treatment infrequently; and in the treatment of nonasthmatic bronchitis."<sup>20</sup>

3. With specific reference to pediatric asthmatics, Dukes, Holgate, and Pauwels issued the following comment that summarizes a reasonable and prudent approach to the management of childhood asthma: "The therapeutic value of inhaled corticosteroids in chronic, severe asthma is unquestioned. In the face of the present trend to use them in larger doses in younger patients, we would advocate a degree of caution in view of our lack of knowledge of how serious the side effects may turn out to be with longer term use, and we see no reason why patients at the milder end of the asthmatic spectrum should not receive a trial of around two months with the non-



steroidal drugs, nedocromil sodium or sodium cromoglycate (cromolyn sodium), reserving the inhaled corticosteroids for the cases where either these drugs do not work sufficiently well alone or where asthma is more severe.”<sup>3</sup> ■

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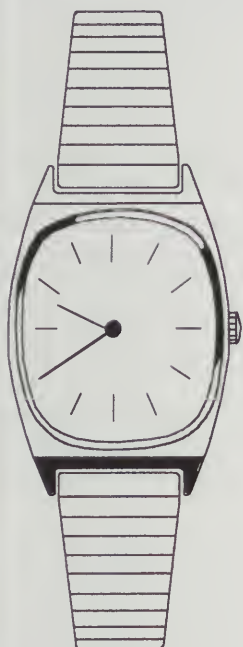
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This article was compiled by Drs. A.H. Wolff and Leonard Bielory. Address reprint requests to Dr. Bielory, Director, Asthma & Allergy Research Center, UMDNJ-New Jersey Medical School, 90 Bergen Street, Suite DOC 4700, Newark, NJ 07103-2499.

# DO YOU HAVE THE RIGHT TIME?

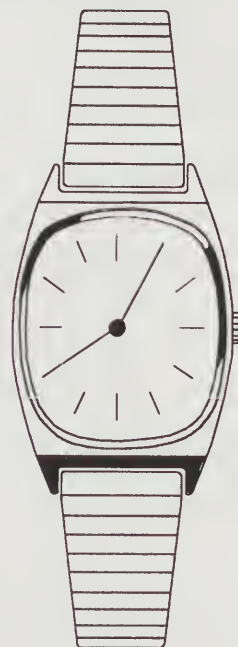
It's 9:40  
In the morning ...  
you felt a sharp  
pain in your right  
arm and side ...



It's 3:35  
In the afternoon ...  
the doctors confirmed  
that it **WAS** a  
heart attack ...



It's 8:05  
In the evening and  
you begin to wonder  
"How much Disability Income  
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# **MEDICAL SOCIETY OF NEW JERSEY 1996 ANNUAL MEETING**

*May 1 through May 4, 1996  
Trump Taj Mahal Casino/Resort  
Atlantic City, NJ*

## **DAILY SCHEDULE**

### **WEDNESDAY, MAY 1, 1996**

- 8:00 A.M. Registration Opens
- 8:30 A.M. Message Center Opens
- 9:00 A.M. AMA Delegation Meeting
- 10:00 A.M. Educational Program
- 11:30 A.M. The Academy of Medicine of New Jersey Lecture
- 12:30 P.M. Exhibits and AMA-ERF Boutique Open
- 1:30 P.M. House of Delegates
- 3:00 P.M. Reference Committees
- 7:00 P.M. Officers' Reception/Dinner

### **THURSDAY, MAY 2, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. Reference Committees
- 9:30 A.M. Exhibits Open
- 12 NOON Golden Merit Award Ceremony/Reception
- 1:30 P.M. House of Delegates (Election)
- 4:00 P.M. JEMPAC Political Forum
- 5:00 P.M. JEMPAC Wine and Cheese Reception
- 6:00 P.M. Camden County Medical Society Reception Honoring President and Mrs. Louis L. Keeler

### **FRIDAY, MAY 3, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. House of Delegates
- 9:30 A.M. Exhibits Open
- 12:30 P.M. Luncheon Meeting—Members of the Hospital Medical Staff Section
- 1:00 P.M. Exhibits Close
- 7:00 P.M. Inaugural Reception
- 8:00 P.M. Inaugural Dinner Honoring Anthony P. Caggiano, Jr, MD

### **SATURDAY, MAY 4, 1996**

- 8:00 A.M. Registration Opens
- 8:00 A.M. Message Center Opens
- 8:30 A.M. HIV Educational Program

HEADQUARTERS HOTEL

**HOUSING APPLICATION  
230th ANNUAL MEETING  
MEDICAL SOCIETY OF NEW JERSEY  
APRIL 30-MAY 4, 1996**

**TRUMP TAJ MAHAL CASINO/RESORT**

**1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401**

**RESERVATIONS DEPARTMENT 1-800-825/8786**

*(Please Print)*

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_

Sharing With \_\_\_\_\_

Date of Arrival \_\_\_\_\_ Time \_\_\_\_\_

Date of Departure \_\_\_\_\_ Time \_\_\_\_\_

***A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the TRUMP TAJ MAHAL CASINO/RESORT or complete the following:***

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**SCHEDULE OF RATES SUBJECT TO 12% TAX**

( ) SINGLE \$110 ( ) DOUBLE \$110 ***(Reservations must be received prior to March 30, 1996.)***

Extra Person \$25

( ) One-Bedroom Suite \$275 per day

( ) One-Bedroom Hospitality Suite \$350 per day

Check-out time is 12 NOON. Rooms may not be available for check-in until after 4 P.M. Check-in time on Sunday, is 6 P.M. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION IS REQUIRED FOR A FULL REFUND. PARKING: There is a state-imposed \$2 minimum charge per 24-hour period for each motor vehicle parking on the premises.

( ) Check if official delegate County \_\_\_\_\_

PLEASE NOTE: Current state sales tax is 3 percent and occupancy tax is 9 percent, and room usage fee is \$2 per room, per night. These taxes are subject to change, without notice.

The proceeds from the fees collected shall be paid into a special fund that will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts, and casino gaming.

**MAIL THIS APPLICATION TO: Reservations**

Trump Taj Mahal Casino/Resort  
1000 Boardwalk at Virginia Avenue  
Atlantic City, NJ 08401



# DOCTORS' NOTEBOOK

## TRUSTEES MINUTES

A regular meeting of the Medical Society of New Jersey (MSNJ) Board of Trustees was held on January 21, 1996, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

**Congressman Torricelli.** Introduced Congressman Robert Torricelli, Democratic candidate for the U.S. Senate, and questioned him on national issues.

**President's report.** Spoke at the NJ State Department of Health budget hearings to ask Commissioner Fishman to place greater budgetary priority on tobacco control, enforcement of

managed care regulations, family violence prevention, comprehensive school health education, and electronic data interchange.

**Specialty reports.** Received reports from the University of Medicine and Dentistry, the New Jersey Hospital Association, Medical Alliance to MSNJ; and MSNJ Student Association.

**HMO Advisory Committee.** Acknowledged "Putting Patients First," a document containing comments drafted by MSNJ to Commissioner Fishman's proposal to stiffen regulation of HMOs. Noted that Dr. Palace served as the providers' spokesperson. Also noted that a key point of controversy was Commissioner Fish-

man's proposal to establish an independent appeal mechanism for utilization review decisions; HMO representatives strongly opposed the idea.

**Executive director's report.** Noted the following: quarterly meetings with the New Jersey State Department of Insurance to discuss managed care issues that have been established; and the Medical Practice Manager Program, developed by MSNJ and Rutgers, has begun.

**Physician Healthcare Plan of New Jersey, Inc. (PHPNJ).** Noted that PHPNJ is licensed to operate an HMO statewide and the new prospectus will be mailed shortly.

**Study of the federation.** Received a report from Irving P. Ratner, MD, chair of the AMA delegation; comments on the report that studied the federation over the past two years will be presented at the next Board of Trustees meeting.

**New business.** Adopted the following motion: Directing the executive committee and the Committee on Revision of Constitution and Bylaws to develop a proposed amendment to the Bylaws that would permit two trustees from the First District to maintain seats on the Board of Trustees, and if the amendment is adopted by the 1996 House of Delegates, that a special election be conducted during the Annual Meeting to elect a second trustee from the First District. [It was noted that the First District would lose a trustee since membership dropped from 2,522 to 2,495 as of December 31, 1995.] ☐

## ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name \_\_\_\_\_

Old Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

New Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

## MEDICAL ALLIANCE TO MSNJ

Bicycling is not just for children and teenagers. It is a popular fitness activity for health-conscious adults and provides an alternative means of commuting for the environmentally conscious. However, bicycling without a helmet can lead to serious head injuries. A helmet is essential and can greatly reduce the chance of injury.

A national study noted the following annual statistics: head injuries are noted in 65,000 emergency room visits and in 7,700 hospital admissions; 40 percent of bicyclists are admitted to hospitals as are 70 to 80 percent of fatally injured bicyclists.

Bicyclists hospitalized with head injuries are 20 times as like-

ly to die as those without head injuries. The highest injury rate of bicyclists are between ages 5 to 15, and 56 percent of fatally injured bicyclists are age 20 or older. Death rates for male bicyclists ages 20 to 54 have substantially increased in recent years.

A good helmet protects the head by giving the skull and brain a little time to match speeds with suddenly encountered objects. The outer plastic shell adds load-spreading capacity and prevents objects from penetrating the helmet, causing injury to the head. The main body of the helmet has ventilation holes and is made of dense, crushable material that distributes and ab-

sorbs the energy of an impact. During an impact, the head actually crushes the helmet. The brain gains time and distance to slow down. As the helmet is crushed, it applies sufficient force to slow the head to a relatively gentle stop rather than the potentially lethal levels of force the head would sustain without a helmet.

Helmets must be worn low on the forehead just above the eyebrows with the chin strap fastened. The Snell Foundation, a nonprofit organization dedicated to the public testing of helmets, suggests that helmets should be replaced if damaged and/or replaced every five years. □  
Christine Kline, president

## UMDNJ NOTES

### *Institute to address violence.*

The creation of an institute that will address the leading public health problem in today's society—violence—was announced at the annual University Day program of the University of Medicine and Dentistry of New Jersey (UMDNJ). This new initiative, announced as part of my State of the University speech, is dedicated to reversing a rising trend of violence in families, classrooms, neighborhoods, and communities.

Information from public opinion polls reflects this trend. One national poll found that of 2,000 teenagers, 1 in 8 carried a weapon for protection and 2 in 5 carried weapons in high-crime neighborhoods. A poll conducted by UMDNJ and the Eagleton Institute last fall revealed that 61 percent of New Jerseyans feel more threatened by violence now than they did five years ago and 30 percent now feel more threatened in their own neighborhoods.

The address also focused on UMDNJ's tradition of teaching excellence that will ensure continuing UMDNJ success despite fiscal belt tightening and a chang-

ing health care environment. University Day activities also included the announcement that Governor Christine Todd Whitman was selected to receive UMDNJ's Medal for Distinguished Leadership. She was cited for the distinction of becoming the first woman elected to the state's highest office and for her efforts on behalf of higher education and health care delivery.

The Board of Trustees observed my 25th year as president of UMDNJ by presenting me with the University Medal. In the accompanying resolution, the Board of Trustees cited numerous presidential initiatives that have made UMDNJ the nation's largest freestanding university for the health sciences, including development of major research, educational and community service programs; increasing minority representation in the health professions; establishing partnerships and collaborations with other higher education institutions and health care facilities; and introducing biomedical ethics into the medical school curriculum.

Five employees and a com-

munity outreach program were presented University Excellence awards for outstanding contributions. The recipients were: Dr. Walter Duran, professor of physiology at UMDNJ-New Jersey Medical School; Dr. Michael M. Lyons, professor of laboratory medicine and pathology at UMDNJ-New Jersey Medical School; Dr. Frank V. Castello, assistant professor of clinical pediatrics and director, Division of Pediatrics Intensive Care Unit, UMDNJ-Robert Wood Johnson Medical School; Laura Mayer, an analyst in the Department of University Libraries; Luz Ortiz, recruiter/counselor for minority and disadvantaged students at UMDNJ-Robert Wood Johnson Medical School; and the Center for Children's Support at UMDNJ-School of Osteopathic Medicine, Stratford.

**UMDNJ yields \$1.7 billion return to taxpayers.** The \$301 million that UMDNJ received from New Jersey taxpayers in 1994 translated into a nearly \$1.7 billion boost to the state's economy, according to a new report released by UMDNJ. A large part of that return on invest-



ment—\$916 million—was derived from UMDNJ purchases of goods and services from New Jersey businesses, combined with employee and student spending in the state.

Since 60 percent of UMDNJ's budget is derived from non-state sources, UMDNJ returns dollars to the state economy many times over what it consumes in taxpayer support.

The 36-page report on UMDNJ's economic impact was compiled by UMDNJ's Department of Urban and Community Development. Using 1994 figures as a barometer, the report provides an indepth look at how UMDNJ advances the economy of its host communities and the state in general.

**New director of clinical affairs and patient-based research.** Dr. Neil S. Cherniak, former dean of Case Western Reserve University School of Medicine, has been named director of clinical affairs and patient-based research at UMDNJ-New Jersey Medical School. In this post, he will establish a network of patient care programs with community hospitals in northern New Jersey. These programs will be part of the school's clinical education programs and northern New Jersey's health care network of the University HealthCare System, UMDNJ's statewide managed care network. These programs will be linked to UMDNJ-University Hospital, the tertiary care center for the northern Jersey

network. Dr. Cherniak has also been appointed professor in the Departments of Medicine and Physiology at the medical school.

**Free cancer screenings to minority women.** The New Jersey State Department of Health has awarded a \$90,000 grant to UMDNJ-New Jersey Medical School to provide free breast and cervical cancer screenings to uninsured or underinsured Essex County minority women.

Minority women who are 40 years of age or older and live in Essex County can receive free mammographies, clinical breast examinations, and Papanicolaou smears at the Women's Wellness Center on the Newark campus. □ Stanley S. Bergen, Jr, MD

## PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in further information concerning these physicians, please direct inquiries to them.

### Anesthesiology

**Geoffrey W.T. Ndeto, MD**, 36 Franklin Ave., Rosemont, PA 19010. Nairobi (Kenya) 1976. Group or partnership. Available.

### Gastroenterology

**Simhjadri Kompella Sastry, MD**, 15A Lakeview Ave., Leonia, NJ 07605. Andhra Medical College 1976. Board certified (IM). Board eligible (GI). Solo or partnership. Available.

**Rawel Singh, MD**, 8569 Everett Ave., St. Louis, MO 63117. GND

University (India) 1980. Board certified. Single or multispecialty group. Available.

### Internal Medicine

**Howard M. Abrams, MD**, 1175 York Avenue, Apt. 3K, New York, NY 10021. UMDNJ 1984. Board certified (IM and GI). Group with partnership. Available soon.

**T.S. Krishnaswamy, MD**, P.O. Box 98765, Tacoma, WA 98498. Jipmer Medical School (India) 1962. Board eligible. Group, partnership, solo. Available.

**Ashwin N. Trivedi, MD**, 71 Webster St., Floral Park, NY 11001. Baroda Medical College 1980. Board eligible. Group or solo. Available.

### Nephrology

**Suk Hyeon Yun, MD**, 504 Summit Ave., Fort Lee, NJ 07024. New York Medical College 1989. Board

certified (IM). Board eligible (NEPHR). Group or partnership. Available.

### Psychiatry

**Dorothy Brozek, MD, MSN**, 200 E. Wynnwood Rd., D-1, Wynnwood, PA 19096. Albany Medical College 1990. Group or partnership. Board eligible. Available.

### Surgery

**Eric Gross, MD**, 26 Chestnut Ridge Lane, Amberst, NY 14228. Mt. Sinai School of Medicine (New York) 1988. Board eligible. Group or partnership. Available.

### Urology

**Richard P. Campo, MD**, 1130 McIntyre, Ann Arbor, MI 48105. Mt. Sinai School of Medicine 1989. Available.

# Hahnemann University Hospital

## Department of Medicine Grand Rounds Wednesdays 8:30 to 9:30 a.m.

Classroom C (Alumni Hall), 2nd Floor, New College Building, Hahnemann University, 15th & Vine Streets (15th Street Entrance), Philadelphia  
For more information, contact the Office of Continuing Education at 215-762-8263.

### APRIL 1996

APRIL 3rd

#### The Calcium Antagonist Controversy

*Franz Messerli, M.D.*

Clinical Professor of Medicine

Fulane University School of Medicine, Director,

Hypertension Laboratory, Ochsner Clinic,

New Orleans, LA

#### Racial Differences in the Treatment of Hypertension

*Barry J. Materson, M.D.*

Professor of Medicine

University of Miami School of Medicine, Miami, FL

APRIL 10th

#### The Thrombosis Prone Patient: Abnormalities of Protein C and Factor V

*John C. Hoak, M.D.*

Former Director, Division of Blood Diseases and

Resources, National Heart, Lung and Blood

Institute (NHLBI), Clinical Professor of Medicine,

Uniformed Services University of the Health

Sciences, Consultant to Walter Reed Army

Hospital, Bethesda, MD

### APRIL 1996

APRIL 17th

#### Treatment of HIV and Related Opportunistic Infections

*Martin S. Hirsch, M.D.*

Professor of Medicine

Harvard Medical School, Head, Infectious Diseases

Unit, Massachusetts General Hospital, Boston, MA

APRIL 24th

#### Abnormalities of Growth Hormone

*Lawrence A. Frohman, M.D.*

Edmund F. Foley Professor and Head Department

of Medicine, University of Illinois at Chicago,

Chicago, IL

### MAY 1996

MAY 1st

#### New Concepts in the Management of Atrial Fibrillation

*Peter L. Friedman, M.D., Ph.D.*

Associate Professor of Medicine

Co-Director, Cardiac Arrhythmic Service and

Clinical Electrophysiology Laboratory,

Cardiovascular Division, Brigham and Women's

Hospital, Boston, MA

### MAY 1996

MAY 8th

#### Advances in the Treatment of NIDDM

*Alan J. Garber, M.D., Ph.D.*

Professor of Medicine, Biochemistry and Cell

Biology, Baylor College of Medicine,

Houston, TX

MAY 15th

#### The Kidney as a Window for Cardiovascular Morbidity and Mortality

*Leopoldo Raij, M.D.*

Professor of Medicine

University of Minnesota School of Medicine, Chief,

Nephrology/Hypertension, Veterans Affairs

Medical Center, Minneapolis, MN

MAY 22nd

#### New Pharmacotherapy for Allergic Rhinitis

*Lanny Rosenwasser, M.D.*

Professor of Medicine

University of Colorado Health Science Center,

Head, Allergy Division, National Jewish Center for

Immunology and Respiratory Medicine,

Denver, CO

MAY 29th

#### No Grand Rounds

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

APRIL 3, 1996

#### Hypertension: Understanding the Controversies in the Treatment of Hypertension

*Franz Messerli, M.D., Barry J. Materson, M.D.*

APRIL 17, 1996

#### Treatment of HIV and Related Opportunistic Infections

*Martin S. Hirsch, M.D.*

MAY 8, 1996

#### Prevention and Treatment of Complications of Diabetes Mellitus

*Alan J. Garber, M.D., Ph.D., Harry Gottlieb, M.D.*

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

**Full Disclosure Statement:** All faculty participating in continuing medical education programs sponsored by The Medical College of Pennsylvania and Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

**Statement of Accreditation:** The Medical College of Pennsylvania and Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The Medical College of Pennsylvania and Hahnemann University designates 1.0 credit hour of Category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities.

This program is eligible for 1.0 credit hour for each hour of attendance in Category 2A of the American Osteopathic Association.



# CONTINUING EDUCATION

## MEDICINE

The following is a list of continuing medical education courses for the next two months. Contact the sponsoring organization (in *italics*) for further information.

### March

- 13 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 16-17 **37th Annual NJ Postgraduate Anesthesia Seminar**  
Trump Plaza Hotel & Casino,  
Atlantic City (*AMNJ*)
- 18 **Role of CGMP in Visual Signal Transduction**  
UMDNJ-School of Osteopathic Medicine, Stratford (*UMDNJ*)
- 20 **Family Medicine Series**  
UMDNJ-Robert Wood Johnson Medical School, Camden  
(*Cooper Hospital*)
- 20 **Thriving in a Competitive Environment: Strategies for Success**  
MSNJ Headquarters,  
Lawrenceville (*AMNJ*)
- 20 **Collagen Disease Update**  
St. Mary's Hospital, Passaic  
(*AMNJ*)
- 20 **Prevention of Lower Extremity Amputation**  
The General Hospital Center at Passaic, Passaic (*AMNJ*)
- 20 **13th Annual Symposium on Facial Plastic Surgery**  
Garden State Arts Center,  
Holmdel (*AMNJ*)
- 20 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 20 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 21 **Diagnostic Radiology Section Meeting**  
St. Barnabas Medical Center,  
Livingston (*AMNJ*)
- 27 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 27 **Medical Grand Rounds**

VA Medical Center,  
East Orange (*AMNJ*)

- 28 **Visiting Professor Lecture**  
St. Barnabas Medical Center,  
Livingston (*AMNJ*)
- 29 **Neuropsychiatric and Psychosocial Aspects of HIV/AIDS**  
Union Hospital, Union (*AMNJ*)
- 29-31 **Semmelweis-Waters Ob/Gyn Conference**  
Bally's Park Place, Atlantic City  
(*UMDNJ*)

### April

- 3 **Treatment of Epstein-Barr Virus and Cytomegalovirus**  
The General Hospital Center at Passaic, Passaic (*AMNJ*)
- 3 **Overview of Cervical Neoplasia**  
Corning Clinical Laboratories,  
Teterboro (*AMNJ*)
- 3 **Present State of Snoring and Sleep Apnea**  
St. Mary's Hospital, Passaic  
(*AMNJ*)
- 3 **Interhospital Endocrine Rounds**

University Hospital, Newark  
(*AMNJ*)

- 3 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 8 **Monthly Dermatology Meeting**  
Schering Corporation,  
Kenilworth (*Dermatological Society of NJ*)
- 10 **Psychiatry: Medication Interactions**  
St. Mary's Hospital, Passaic  
(*AMNJ*)
- 10 **Interhospital Endocrine Rounds**  
University Hospital, Newark  
(*AMNJ*)
- 10 **Medical Grand Rounds**  
VA Medical Center,  
East Orange (*AMNJ*)
- 11 **Scientific Meeting: Head and Neck Oncology Section**  
The Manor, West Orange  
(*AMNJ*)
- 12 **Isoprostanes and Oxidant Stress**  
UMDNJ-School of Osteopathic Medicine, Stratford (*UMDNJ*)

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## **Bayshore Community Hospital** Holmdel, NJ

### **Continuing Medical Education Lecture Series 12 noon-1 pm**

- Date: March 15, 1996  
Topic: "Prophylaxis and Coagulation of Atrial Fibrillation"  
Speaker: Michael Ezekowitz, MD
- Date: March 22, 1996  
Topic: "Respiratory Tract Infections"  
Speaker: Nasser Shariati, MD
- Date: March 29, 1996  
Topic: "Management of the Chronic Pain Patient"  
Speaker: David Handlin, MD
- Date: April 5, 1996  
Topic: No Lecture—Good Friday
- Date: April 12, 1996  
Topic: "Parkinson Disease"  
Speaker: Jacob I. Sage, MD
- Date: April 19, 1996  
Topic: "Osteoporosis: New treatment"  
Speaker: Avedis K. Khachadurian, MD
- Date: April 26, 1996  
Topic: "Non-malignant/Malignant Pain Management"  
Speaker: Elizabeth J. Narcissian, MD

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**Registration Fee**

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- |       |   |       |  |    |  |
|-------|---|-------|--|----|--|
| 16-21 | <b>Annual Spring Meeting: NJ Orthopaedic Society</b><br>Four Seasons Resort, Nevis, West Indies (AMNJ)          | 17    | <b>Interhospital Endocrine Rounds</b><br>University Hospital, Newark (AMNJ)  | 24 | <b>Minimizing Liability under Managed Care</b><br>MIIX, Lawrenceville (MIIX and UMDNJ)                                     |
| 17    | <b>Making Decisions in Transfusion Medicine</b><br>The General Hospital Center at Passaic, Passaic (AMNJ)       | 17    | <b>Medical Grand Rounds</b><br>VA Medical Center, East Orange (AMNJ)   | 24 | <b>30th Annual William P. Burpeau Award Dinner and Lecture</b><br>The Manor, West Orange (AMNJ)                            |
| 17    | <b>Thriving in a Competitive Environment: Strategies for Success</b><br>MSNJ Headquarters, Lawrenceville (AMNJ) | 18    | <b>Diagnostic Radiology Section and NJ Institute of Ultrasound in Medicine Meeting</b><br>St. Barnabas Medical Center, Livingston (AMNJ) | 24 | <b>Interhospital Endocrine Rounds</b><br>University Hospital, Newark (AMNJ)  |
| 17    | <b>Magnetic Resonance Imaging of the Nondegenerative Disease of the Spine</b><br>Cooper Hospital, Camden (AMNJ) | 18-19 | <b>Practical Primary Care of Female Patients</b><br>Ocean Place Hilton, Long Branch (UMDNJ)  | 24 | <b>Medical Grand Rounds</b><br>VA Medical Center, East Orange (AMNJ)   |
| 17    | <b>Estrogen Replacement Therapy and Management of Menopause</b><br>St. Mary's Hospital, Passaic (AMNJ)          | 23    | <b>Radiological Society of New Jersey Annual Meeting</b><br>Hyatt Regency, New Brunswick (AMNJ)  | 25 | <b>Visiting Professor Lecture</b><br>St. Barnabas Medical Center, Livingston (AMNJ)  |
| 17    | <b>Family Medicine Series</b><br>UMDNJ-Robert Wood Johnson Medical School, Camden (Cooper Hospital)             | 24    | <b>23rd Annual Pacemaker Meeting</b><br>Sheraton at Woodbridge Place, Iselin (AMNJ)  | 26 | <b>Minimizing Liability under Managed Care</b><br>UMDNJ-Robert Wood Johnson Medical School, New Brunswick (MIIX and UMDNJ) |

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Writer Bill Berlin will tell you the facts on managed care and physicians' first option.
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Find out how Drs. Damato, Jayaram, and Moussa analyzed the data.
- Want to know the inside scoop from Steve Adubato?  
Read Steve Adubato's interview with Uwe Reinhardt.
- Can a plate of pasta affect your mood?  
Two New Jersey nutritionists update you about carbohydrates.
- What's on the cutting edge at New Jersey's University of Medicine and Dentistry?  
Learn the latest about UMDNJ from its president, Dr. Stanley Bergen.
- Nurse practitioners: What is their role in doctors' offices?  
In a point counterpoint, health care professionals debate their positions.
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ANDREW SPIELMAN, S.B., S.D., M.A. (Hon.), is a pioneer in the development of methods of diagnosing vector-borne disease and for protecting people against infection. His recent efforts have largely been directed toward an analysis of the environmental factors that promote the emergence of Lyme disease and human babesiosis. He is the author of more than 250 publications and holds three patents. Currently, he is a professor of tropical public health at Harvard School of Public Health.

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# IN MEMORIAM

## ROBERT A. KRITZLER

We have been informed of the death of Robert August Kritzler, MD, on March 31, 1995. Born on March 1, 1915, in New York City, Dr. Kritzler was graduated from Cornell University Medical College, New York, in 1940. He completed a residency at Presbyterian Hospital, New York. Dr. Kritzler specialized in internal medicine and maintained a private practice in Ridgewood. During his medical career, Dr. Kritzler was director of medicine and past-president of the medical board at

Valley Hospital, Ridgewood; a trustee of the West Bergen Mental Health Center; and a member of the teaching faculty at Columbia University, New York. Dr. Kritzler was a member of our Bergen County component and of the American Medical Association. He also was a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine and of Pathologic Anatomy. Dr. Kritzler served in the United States military during World War II.

## EDWARD R. NEARY

Eighty-three-year-old Edward R. Neary, MD, of Spring Lake Heights, died on January 17, 1995. Dr. Neary was born on October 13, 1911, in Jersey City, and was a 1937 graduate of Jefferson Medical College, Philadelphia. He served an internship at Holy Name Hospital, Teaneck. During his long medical career, Dr.

Neary maintained a medical practice in Teaneck and Palisades Park and was the medical director of Schering-Plough Corporation, Kenilworth. Dr. Neary was a member of our Monmouth County component and of the American Medical Association. Dr. Neary resided in Teaneck and Colts Neck.

## NATHAN NUSSBAUM

A member of the Passaic County Medical Society, cardiologist Nathan Nussbaum, MD, passed away on March 15, 1995. Dr. Nussbaum was born on February 19, 1909, in Brooklyn, New York. In 1937, he was awarded a medical degree from the University of Vienna, Austria. Dr. Nussbaum served an internship at Misericordia Hospital and a residency at Sea View Hospital, both

in New York. During his long medical career, Dr. Nussbaum maintained offices in Passaic and Clifton and was affiliated with Beth Israel Hospital and the General Hospital Center at Passaic, both in Passaic. Dr. Nussbaum was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Cardiology

## WILLIAM D. VAN RIPER

We regret to announce the death of William Drexler Van Riper, MD, on February 4, 1995. Dr. Van Riper was born on May 29, 1910, in Paterson, was graduated from Temple University School of Medicine, Philadelphia, in 1939, and received a

New Jersey medical license the following year. During his career in occupational medicine, Dr. Van Riper was affiliated with Riverside Hospital, Boonton; maintained an office in New Brunswick; and was a member of our Middlesex County component, of

The Academy of Medicine of New Jersey, and of the American Medical Association. He also was the director of industrial medicine at Johnson & Johnson. Dr.

Van Riper was a fellow of the American Public Health Association. Dr. Van Riper served in the United States Army during World War II.

## GEORGE J. RASKIN

Born on August 21, 1907, in New York City, George Joseph Raskin, MD, passed away on November 13, 1994. Dr. Raskin was awarded a medical degree from the University of St. Louis School of Medicine, Missouri, in 1933. He completed an internship at Knickerbocker Hospital and Morrisania City Hospital, both in New York. Dr. Raskin completed a residency at Harlem Hospital and Morrisania City Hospital,

both in New York. Dr. Raskin received New York and New Jersey medical licenses in 1934 and 1948, respectively. During his career as a family practitioner, Dr. Raskin maintained practices in New York City and Woodcliff Lake. He was affiliated with Pascack Valley Hospital, Westwood. Dr. Raskin was a member of our Bergen County component and of the American Medical Association.

## ROBERT E. STEWARD

We regret to announce the death of Robert Edward Steward, MD, on November 19, 1994. Dr. Steward was a senior partner with the New Brunswick Pediatric Group. During his medical career as a pediatrician, Dr. Steward was on the teaching faculty of New Jersey College of Medicine, Newark; was affiliated with Robert Wood Johnson University Hospital and St. Peter's Medical Center, both in New Brunswick, and University Hospital, Newark; and was past-president of our

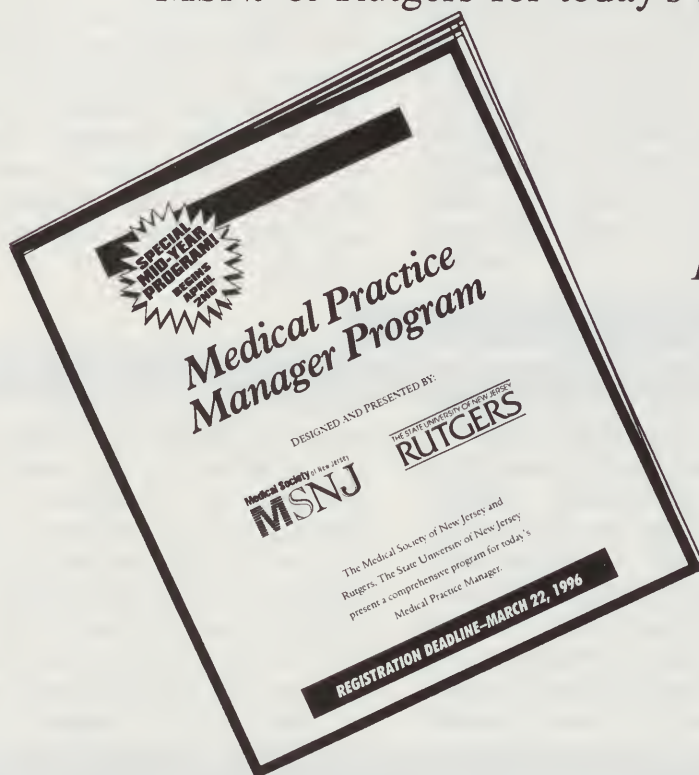
Middlesex County component. He also was a member of the American Medical Association, and a fellow of the American Academy of Pediatrics. Dr. Steward was born on January 28, 1937, in Trenton, and was a 1963 graduate of Seton Hall College of Medicine and Dentistry, Jersey City. He completed an internship at Jersey City Medical Center and a residency at Newark City Hospital. Dr. Steward served in the United States Army as a captain from 1964 to 1966.



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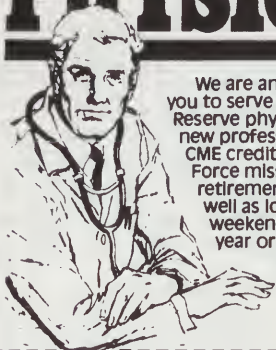
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NEW JERSEY MEDICINE

04/17/96

# NEW JERSEY MEDICINE

*Health Care in the Garden State*

*April 1996*

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New Jersey MEDICINE

## newsWATCH

A flurry of mergers is dusting New Jersey's acute care hospitals, which traditionally have been community-based, moderately sized, not-for-profit, and organized to respond to a high degree of state regulation. If successful, the merger mania may protect hospitals from rampant takeovers by giant out-of-state, for-profit systems.

Last month a hookup with Muhlenberg Regional Medical Center was announced by the Robert Wood Johnson Health System, which already had embraced Rahway Hospital, Raritan Bay Medical Center, RWJ University Hospital in Hamilton, CentraState Medical Center, and Helene Fuld Medical Center.

Saint Barnabas Medical Center has forged links with the United Healthcare System, Clara Maass Health System, Community-Kimball Health Care System, Newark Beth Israel Medical Center, Irvington General Hospital, Monmouth Medical Center, and Union Hospital.

Hospital action mirrors waves in the pharmaceutical industry, which has a huge base in New Jersey. The merger of Ciba-Geigy Ltd. and Sandoz Ltd., also announced in March, follows similar, earlier reported deals by Upjohn Co. and Pharmacia AB, Hoechst AG and Marion Merrell Dow Inc., Glaxo PLC and Wellcome PLC, American Home Products Corp. and American Cyanamid Co., and Roche Holding Ltd. and Syntex Corp.

**Legislation to prevent one-day maternity stays in hospitals appears to have had an effect.**

The measure whipped through the Legislature last year and was signed by Governor Whitman at Holy Name Hospital on June 28. During the next six months, according to data collected by the state Department of Health (DOH), the average length of stay for maternity cases rose almost 50 percent, from 1.3 to 1.9 days.

Hospitals complain, though, that they—not managed care plans—are bearing the cost of the increase, as HMOs decline to provide reimbursement commensurate with longer stays.

Meanwhile, managed care plans—whose actions led to the ban on early maternity discharges, or so-called “24-hour law”—have become hugely popular with New Jersey employers. The 1995 Health Benefits Survey conducted by the **New Jersey Business & Industry Association (NJBIA)** revealed that 53 percent of all plans purchased by employers involved managed care. The survey also disclosed an increase of only 1 percent—to \$4,493 per employee—in the annual cost of employer-financed health care coverage last year.

The NJBIA finding compares to a 3.5 percent nationwide increase—to \$4,181—in health care spending by large employers, found by Foster Higgins.

In the first major instance of physician-payer collaboration, the new **Physician Healthcare Plan of New Jersey (PHPNJ)**, the state's sole doctor-owned HMO, joined the Health Care Payers Coalition of New Jersey in a plan to generate medical outcomes data, arrayed by physician, to help make the Coalition a



more informed purchaser of care. The Coalition is PHPNJ's first major client.

Physician assays into the business side of managed care ran into one obstacle, however, when the Antitrust Division of the federal Department of Justice on March 1 dashed a scheme by pediatricians in southern New Jersey to set up a network of 65 to 70 physicians—most of the pediatricians practicing in the service area. The Justice action was an exception to the leniency now generally shown by the Department and Federal Trade Commission toward provider networks.

**Also on the managed care front, on March 14 the Health Committee of the State Senate unanimously approved the Health Care Quality Act (S-269), sponsored by Committee Chairman Jack Sinagra (R-Edison). The bill, similar to the Patient Protection Act (A-1393) sponsored in the lower house by Assemblywoman Charlotte Vandervalk, was amended to prohibit "gag clauses" preventing physicians from discussing all treatment options with patients and to require medical directors of managed care plans to be licensed to practice medicine in New Jersey.**

The state's HMO Association, which has led opposition to the Sinagra and Vandervalk measures, accepted the two amendments without argument. But, association officials came under rough questioning from Democratic committee mem-

bers Richard Codey of West Orange and Ronald L. Rice of Newark. Senator Codey objected to financial incentives against treatment, while Senator Rice worried about the processes used to terminate providers.

Stronger than the Senate version, the Assembly bill would offer all individuals a point-of-service option, so that even employees covered by an employer-sponsored HMO could select an out-of-network provider at only a slightly increased cost. The Assembly bill also would require managed care plans to establish criteria for terminating providers.

Supporters of these provisions, led by MSNJ, note that they would free employees and their families from having to use physicians and hospitals that are named by the company's plan and are subject to arbitrary dismissal. Other advocates, including the New Jersey Education Association and labor groups, also object to this practice as being patronizing and restrictive. Both the Sinagra and Vandervalk bills would provide consumers with more information about managed care plans and would extend state regulatory sweep over managed care plans other than HMOs. The bills would establish appeal procedures for denials of benefits and would set up requirements for quality improvement and utilization review programs.

Opponents, including the HMO Association and NJBIA, claim that the two provisions would cost employers huge sums of money and would set up a precedent that robs them of control over costs, quality, and personnel.

**Neil E. Weisfeld**

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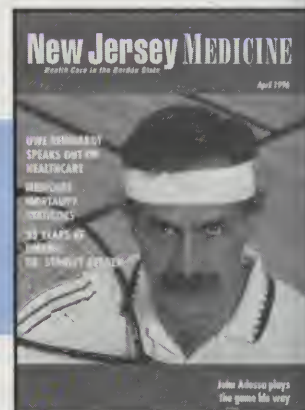
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John Adessa, CEO of First Option Health Plan, explains why Garden State physicians gave this HMO high ratings in a recent survey on managed care companies. Cover: ©Conrad Gloos

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# New Jersey MEDICINE

## *Raising money for charity care in New Jersey*

A recent "Newswatch" section carried some of the administration options that Commissioner Fishman is considering to raise money for charity care. One of the options is a 1.5 percent tax on hospital revenues. Since most of the not-for-profit hospitals seem to show a wash at the end of the year regarding revenues, I would suggest that a different formula be considered. A flat tax on overall administrative costs for hospitals (of course, exclusive of any true cost per patient care) would give the incentive of attempting to keep administrative costs down and, therefore, saving part of the tax. It perhaps would be an incentive to help administration decrease their overall costs that seem to take up a large percentage of monies dedicated to hospitals and patient care.

*Charles Fortunato, MD*

## *Funding for Medicaid*

With over 200,000 beneficiaries enrolled in 14 HMOs, the move to managed care in the Medicaid program is gaining momentum. Enrollment in New Jersey Care 2000, our

managed care program, has tripled during the last year and the push is on to expand the managed care model to other beneficiaries—including people who are elderly or disabled.

Last summer, we began the process of applying for the 1115 waiver from the federal government that would use a managed care model for all Medicaid health services. Besides the acute/medical model already being delivered through HMOs, this waiver called for the state to foster the creation of managed care organizations that would deliver behavioral health and long-term care services, like nursing facility or home- and community-based care options. However, due to uncertainty over the means by which the federal government will fund its portion of the Medicaid program, the state opted to withhold submission of the waiver.

We are proud that through the New Jersey Care 2000 program increasing numbers of our beneficiaries are establishing a personal relationship with a family doctor and are receiving more of the important preventive and well care they need.

We continue to work with other state agencies and providers to establish managed care models to handle the behavioral health and long-term care needs of our beneficiaries and know that, working together with physicians and other health care providers, we can craft a Medicaid system that truly meets the health care needs of all of our beneficiaries and has the added benefit of containing the cost of the program.

*Velvet G. Miller, director,  
New Jersey Division of  
Medical Assistance and Health  
Services*

### **Requirements for letters**

To submit a letter, FAX (609/896-1368) or mail a copy of your letter to *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

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## **Donald C. Huston, Jr., DO**

New Jersey state Board of Medical Examiners

Donald C. Huston, Jr., DO, has been named to the state Board of Medical Examiners (BME). Dr. Huston, president of the Cumberland County Medical Society, a county component of MSNJ, is affiliated with Newcomb Medical Center and with South Jersey Health Systems.



## **Susan Reinhard, RN, PhD**

Senior Assistant Commissioner, Health Planning & Regulation

Commissioner Len Fishman announced the appointment of Susan Reinhard, RN, PhD, as Senior Assistant Commissioner of Health Planning & Regulation. Dr. Reinhard will oversee the Health Facilities Evaluation and Licensing and the Health Care System Analysis divisions of DOH.

## **Commissioner Fishman, Assemblywoman Vandervalk, and AMA's Dr. Todd are three members of the NEW JERSEY MEDICINE Review Board.**

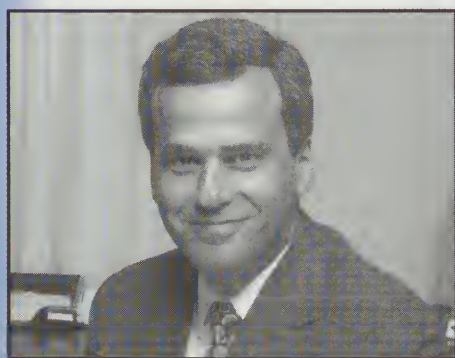
MSNJ is proud to announce the prestigious members of the Review Board for *NEW JERSEY MEDICINE*: From left to right (seated): Howard D. Slobodien, MD; Charles M. Moss, MD; Neil E. Weisfeld, JD, MSHyg [MSNJ Deputy Executive Director]; Earl Wells [MWW/Strategic Communications]; Paul W. Armstrong, Esq; The Honorable Len Fishman;

Richard M. Ball, MD; Carol J. Kientz, RN; and Martin S. Levine, DO. Standing, from left to right, are: Ruth B. Mandel; Dale J. Florio; Paul J. Hirsch, MD; George J. Hill, MD; Louis L. Keeler, MD [MSNJ president]; Gary S. Carter, FACHE; James R. Knickman, PhD; Ismail Kazem, MD; Patricia Murphy, PhD, RN; The Honorable Charlotte Vandervalk; George R. Laufenberg; Bruce G. Coe; Gregg Lubinsky, RPH; Richard Reynolds,



MD; Paul E. Wallner, DO; and Julane Miller.

Missing are Review Board members Stanley S. Bergen, Jr, MD; Harry M. Carnes, MD; and James S. Todd, MD.



## **Paz named dean**

Dr. Harold L. Paz, a noted medical educator and administrator, has been named head of UMDNJ-Robert Wood Johnson Medical School. He has been

serving as acting dean since April 1995. A member of the Mercer County component of MSNJ, Dr. Paz is a respected clinical researcher, especially for his studies on applying new technology to patient care. Many of his studies evaluate treatment of critical care cases.

## **A gift of life for New Jerseyans**

The Donor Enhancement Act, sponsored by Senator Jack Sinagra and Assemblymen

Alex DeCroke and Jeff Warsh, has been signed into law. The new act promotes the goals of the Uniform Anatomical Gift Act, which gives Garden State individuals and their families the power to donate an anatomical gift. Denise Payne, executive director of The Sharing Network, said, "The law will streamline the entire donation process and increase the opportunity for life-saving transplants in New Jersey."

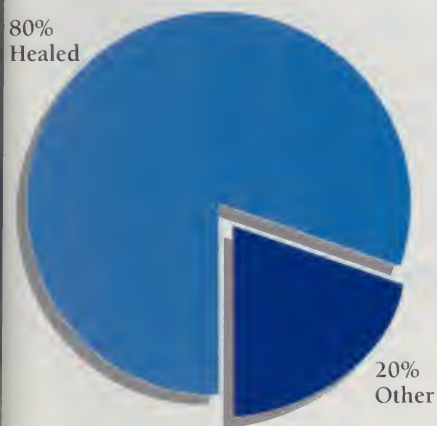
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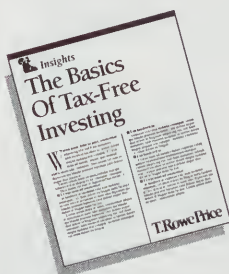
This fund ranks among New Jersey's top-performing municipal bond funds. In addition to its #1 Lipper ranking, the fund has also earned a **four-star (★★★★)** overall rating from Morningstar, an independent publisher of mutual fund ratings. The fund was rated among 835 municipal funds for the three-year period ended 2/29/96.†

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NJB030359

### A redesigned magazine with a new format and purpose await your approval

Last month I outlined the train of events that led to this new version of *NEW JERSEY MEDICINE*, substantially different from its previous versions. But this periodical has undergone many revisions, major and minor; this is merely the most recent.

We hope that the magazine's new cover and interior meet with your approval. These are the first modifications since the spring of 1991, when I outlined the alterations made at that time and felt we had developed "a clean and distinct design that will continue for years." In our current technological environment, five years is a long time; the state-of-the-art computer I bought nine months ago now is severely outdated, although it continues to serve me well.

It is not easy to predict the future, although, as noted by James Atlas in *The New York Times* of December 31, 1995, "Foretelling the future is a venerable literary pastime, ever since Sir Thomas More in 1516 devised his *Utopia*." A week earlier the same newspaper published several predictions

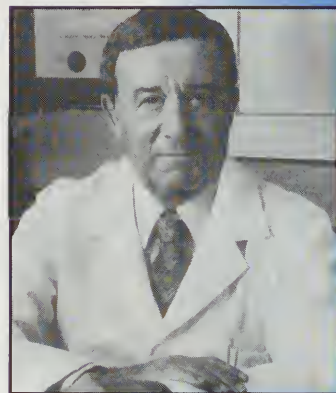
made (by others) in previous years. They included a comment in *Time* magazine on February 25, 1966: "Nearly all experts agree that bacterial and vital diseases will have been wiped out. Probably arteriosclerotic heart disease also will have been eliminated." As Mr. Atlas stated, "Where we're going depends on

where you're coming from—we create the future in our own image." As H.G. Wells put it, "The future is still black and blank—a vast ignorance."

Nevertheless, we proudly present to you the new version of *NEW JERSEY MEDICINE*, completely redesigned and reconstituted in format, approach, and purpose. The renovation has been extensive, but it is not carved in stone or in cement. Areas can be expanded or contracted, new ones can be developed, and other venues can be con-

templated. We welcome your comments.

Turf battles, as noted previously on these pages, have proliferated and intensified. The one between nurses and physicians is espe-



Howard D. Slobodien, MD

*We present to  
you the new  
version of our  
magazine,  
redesigned and  
reconstituted  
in format,  
approach, and  
purpose.*



*It is the nature of a man as he grows older, a small bridge in time, to protest against change, particularly change for the better.*

John Steinbeck, *Travels with Charley: In Search of America*, 1962

*The New is not a fashion, it is a value.*

Roland Barthes, *The Pleasure of the Text*, "Modern," 1975

cially distressing. The one-time estimation of the nurse as the handmaiden of the doctor is no longer tenable and, as both the "point" and "counterpoint" in this issue have noted, both should enjoy a cooperative, perhaps a collegial, association. They have described this relationship in terms of the nurse practitioner, who is considered to "overlap the work of a physician."

Although the nurse practitioner may be a special breed, most nurses have practiced medicine for ages.

Starting IVs, giving IV medication, interpreting EKGs, removing sutures, bandaging, treating minor industrial accidents, and many other activities could all be considered physicians' work, but are routinely done by nurses. Counseling patients on a variety of medical problems has long been a joint venture. Just determining whether a doctor should visit a hospitalized patient because of pain or fever requires diagnostic skills that can allow the overworked practitioner a good night's sleep. The visiting nurses I accompanied on the Lower East Side of New York pursued many of our skills; they continue to do so.

We should recognize that nurses are considered by many to be capable of dealing with minor ailments. I became used to it early in my career when neighbors asked for advice from my wife, even though I was available, because she was a Bellevue nurse. I doubt that my wife's medical knowledge was solicited in order to avoid a fee; many of the same people

also received advice from me, at no charge, on somewhat more serious conditions.

Some physicians will not accept all of the activities noted above as being appropriate procedures for those in other disciplines. More may decry some of the more recent ventures, such as nurses removing tattoos with lasers, as has been reported in Chicago. And even more may rail against nurses taking care of the bread and butter aspects of medical practice while the physician takes care of the (increased) paperwork and telephone consultations engendered by managed care requirements. Some, both nurse and physician, object to the role of the nurse-practitioner as an employee of the physician. Many more find the independent nurse-practitioners or the ones employed by insurers to be the problematic groups. The battle continues, and it is joined by other players, such as physician assistants.

We need understanding all around. Although nurses should not be deemed handmaidens, can't they be considered right arms? Isn't there still need for a captain of the ship, although not necessarily a Captain Bligh? Shouldn't the New Jersey state Boards of Nursing and Medicine be more cooperative and less confrontational, in order to reach, not just agreement, but satisfaction on the part of their licensees? How do we answer the familiar, somewhat pejorative, question, "If they want to practice medicine, why don't they go to medical school?"



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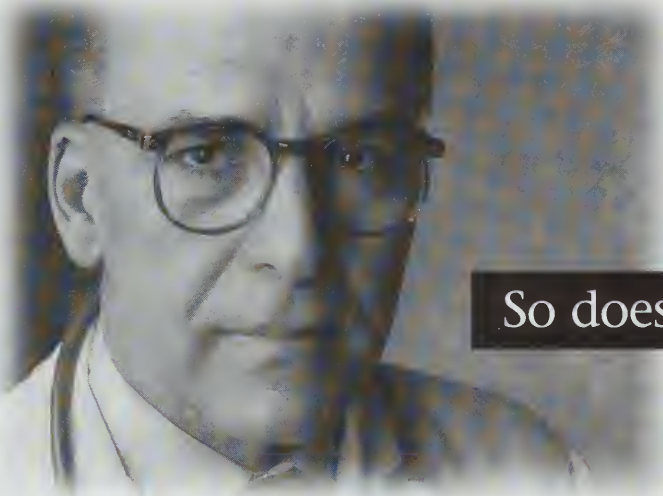
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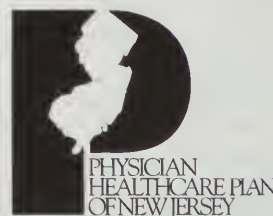


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## INTERVIEW WITH PROFESSOR UWE REINHARDT OF PRINCETON UNIVERSITY

Uwe Reinhardt is the James Madison professor of political economy and professor of economics and public affairs at Princeton University. One of the nation's leading health policy experts, Professor Reinhardt is past-president of the Association of Health Services Research, on

**Q.** You have said that countries like Canada and Germany provide a civilized environment for health care. Do we not have a civilized environment in this country?

**A.** No, I don't think we have a very civilized health system. It's pretty good as far as the clinical quality goes. It's not the delivery system that's bad. It's the insurance system that is chaotic and unreliable. In

**A.** No, I don't believe so. That's okay, but once you have said that you have to develop a health plan tailored to the ethic you prefer. For example, you could say that we want a minimum floor for everyone. We obviously don't want people dying in the streets, but we don't care if everyone has preventive care. Essentially, we are saying that now, but we should be more honest about it.

**Q.** In the end, is this why the Clinton health care plan failed so miserably?

**A.** There were many things the Clintons did that were tactless and tactically wrong, such as the secret task force. In this country to have a secret task force that doesn't keep any secrets is offensive. Number two, they did not invite the Republicans to the table early on. There are some wonderful Republican staffers who are knowledgeable and compassionate and they were not invited. The AMA was not well treated. But you are right: above all the plan failed because it sought to impose an egalitarian health system on a nation that is not egalitarian.



whose board he still serves. He currently is serving his third three-year appointment to the Physician Payment Review Committee, established in 1986.

Canada, it would be unthinkable to tell someone who is chronically ill that we will not insure you.

**Q.** But do you believe that most Americans really want egalitarian health care?



## *In managed care you are limiting yourself to a set of doctors, rather than having totally free choice among doctors and hospitals at the time you are sick.*

**Q.** But since that debate has gone away, the number of uninsured Americans, particularly those who have lost their jobs, has grown. Am I missing something?

**A.** Not at all. We treat this problem the way we treated genital herpes. It was once a big problem, and then we got tired talking about it, and simply pretended that it went away. You have to blame the media a bit for this. A program like *New Jersey Caucus* is refreshingly unusual. The rest of the media goes along with the posture that the problem of the unusual has vanished.

**Q.** But what could the media do, especially the commercial media? Could they cover this issue in a way that still keeps their shareholders happy?

**A.** I think they could, because shareholders don't really mind. There is a large undercurrent of Americans who would like to see this problem solved. If the commercial networks kept this issue in the public eye, shareholders wouldn't mind, nor would advertisers, the health industry, doctors, hospitals, or the pharmaceutical companies.

They would like to see this problem solved. Serving the uninsured is in their interest.

**Q.** Dr. C. Everett Koop has said that the health care issue involves a series of painful choices. Is managed care a good example of this?

**A.** Yes. In managed care you are limiting yourself to a set of doctors, rather than having totally free choice among doctors and hospitals at the time you are sick. When you are sick, you are giving up something. There is something to be said for having the whole range of physicians available to you. But in return for joining an HMO, if it is a good HMO, you will have professionals who will bargain on your behalf for prices and watch for quality. That kind of quality control is most easily had in a completely free choice, fee-for-service system because in that setting one cannot hold doctors and hospitals accountable for the health status of the defined enrolled population.

**Q.** How would you measure quality?

**A.** For one, patient satisfaction. How happy have you been with these doctors,

this hospital, and these nurses? That is now beginning to be done, and the HMOs can claim credit for that.

**Q.** But isn't it true that some of the HMOs are denying physician-recommended care? A while back *Time* magazine reported the case of a young woman with breast cancer who hadn't read her HMO policy, only to find that certain kinds of treatment were not covered. Is this the exception, or is this happening more and more with managed care?

**A.** I think this is probably the exception, but there will be such cases. The problem with our insurance system is that the coverage you buy is not standardized. So you have to read the fine print, and even lawyers don't have time to do this. For reasons like this, we actually need a little more government in health care than we have. Insurance is a product the average person cannot understand.

One reason you feel comfortable eating the food you buy is that government regulates its quality. In homeowners' insurance in this state, there is a fair amount of regulation, and I'm glad we

## Why can't we have a little more regulation for the health insurance product being offered that would exclude the kind of fine print that the average person won't read or understand?

have it. When you get a mortgage, there's government regulation involved in that, in regard to prepayment options, for example. Why can't we have a little more regulation in regard to the health insurance product we are being offered in the marketplace that would exclude the kind of fine print that the average person won't read or understand?

**Q.** But the Republican "revolution" was all about cutting government. They would never accept a thing like that, would they?

**A.** Well, they don't really mean what they say, and let me tell you why. Governor Whitman was the first to go on television and regulate the length of stay that HMOs must pay for after childbirth. As I tell my students, both Democrats and Republicans use the coercive power of government to tell people what to do. They just aim that power at different groups of people.

**Q.** The HMOs wanted a woman out of a hospital one day after childbirth. Is that nuts?

**A.** No, the English have done this for many years. But they follow it up with very solid

home care. When some patients complained about the one-day policy here, Governor Whitman went on TV, and with big brouhaha, she and Republican legislators wound up telling private enterprise what to do. And what she said was really cute. She said, "I



Professor Uwe Reinhardt

want to bring some common sense to this business." So you tell me that Republicans don't like regulation?

**Q.** Where are doctors today? Are their hands tied behind their backs more and more with managed care?

**A.** There is a danger of that, of course. For example, I find it objectionable when doctors have to sign agreements with HMOs that

basically take away their freedom to speak. In fact, some HMOs ask doctors to sign the agreements and then make it illegal to talk about having signed these forms. That is truly Kafkaesque—like out of a horror movie. If the HMO industry knows what is good for it, it will stop this gagging of doctors or government will make the industry stop it.

**Q.** Specifically, what can't a doctor say?

**A.** In some HMOs, a doctor can't tell the patient that there is an alternative and that if you were not in this plan you might be able to get it. I think it's wrong and immoral. At some point, I think doctors have to bring that to the attention of the people and say this won't do. The other thing I think is immoral is to give the physician too much incentive to withhold care. If a doctor says, "You don't need an MRI scan," the doctor should not profit directly from that decision. Some HMOs go too far in this regard. Perhaps they should be told to offer doctors such powerful incentives to withhold care, but that should be disclosed to consumers before they enroll in an HMO.



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## A physician's first option for quality

Bill Berlin

John Adessa is unhappy with the direction managed care has taken in this country, and he is doing something about it. Adessa, the chief executive officer of First Option Health Plan, dislikes the burden of risk that falls on physicians through capitation arrangements, and he does not believe that patients should be severely restricted in their access to physicians.

"We think that managed care is good," Adessa says, "if it involves coordinated care, preventive health services, and the delivery of quality care in the most cost-effective setting. That is not what most health maintenance organizations (HMOs) are doing."

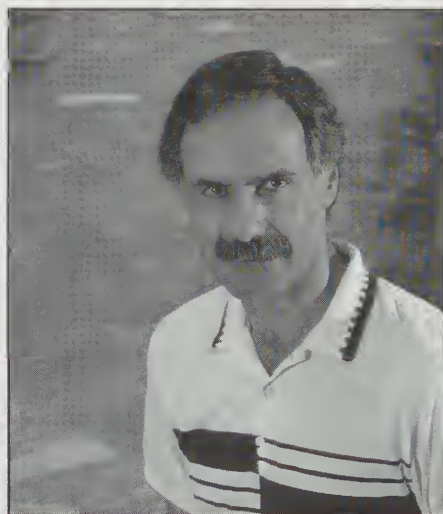
Apparently, Adessa is not alone in this view. A recent report in *The New York Times*, based upon interviews with doctors nationwide, found growing discontent with managed care, especially the constraints that some HMOs impose on the discussion of quality care issues with patients. Often known as

"gag clauses," these provisions limit doctors from recommending treatments not covered by the HMO and from referring to specialists not affiliated with the managed care plan.

In October 1995, MSNJ asked participating physicians to rate 27 HMOs either "excellent to good" or "fair to poor" in respect to sufficiency of reimbursement and commitment of quality of care (Figure). The reviews were clearly mixed. Only one HMO, First Option Health Plan, received higher ratings of "excellent to good" in both categories of evaluation. Two other managed care organizations, Oxford Health Plans and Physician Healthcare Plan of New Jersey (PHPNJ), scored in the higher range in respect to their commitment to quality care.

Among those physicians who responded—about 23 percent of MSNJ's active members—the most frequent comments involved insufficient and tardy reimbursements, denial of care and insensitivity to patients, restrictive policies that exclude many practitioners, and excessive staff time and paperwork.

Since most physicians are wary of HMOs, just what is First Option doing right? And what does the First Option model tell us about the future of managed care?



John Adessa

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First Option differs from most HMOs in that it is provider-owned, with participating physicians possessing equity shares that amount to more than 50 percent of the plan's capital base. By shifting risk to the providers as an ownership group, First Option gives physicians an obvious interest in the organization's success through member-driven governance, operating procedures, and quality controls.

Unlike other managed care organizations, First Option is structured so that medical man-



agement decisions are made by physicians. Providers govern through physician committees, or jointly with participating institutions on the First Option board or executive committee. Physicians make up at least 50 percent of all committees, including the board and executive committee.

As a result, doctors, rather than actuaries or business consultants, decide on protocols, as well as measurement and appropriateness criteria. For example, First Option had to rewrite its first set of criteria after physicians felt that some points were inappropriate.

Adessa emphasizes that quality care concerns mean that there are certain things the organization will not do. "We do not have inappropriate incentives for not providing care," he notes. "We do not give providers a 15 or 25 percent bonus because their utilization rates are down."

Predictably, First Option reimburses providers at a higher rate—51 cents on the dollar, compared to 37 to 40 cents or lower for most HMOs. While the MSNJ survey on HMO satisfaction showed that complaints about delays in reimbursement are not unknown, providers clearly prefer a fee-for-service plan that eschews capitation in favor of more generous reimbursement policy.

Circle the appropriate response. 1 = Excellent to Good 2 = Fair to Poor

Name of HMO	Do you participate in this HMO?	If yes, is there sufficient reimbursement?		Are you satisfied with the HMO quality of care commitment?	
		1	2	1	2
Aetna Health Plans of New Jersey, Inc.					
American Preferred Provider Plan Inc.					
Atlanticare Health Plan Chubbhealth Inc.					
CIGNA Health Plan of Southern New Jersey					
CIGNA of Northern New Jersey, Inc.					
Community Health Care & Development Corp.					
Delaware Valley HMO					
First Option Health Plan					
Garden State Health Plan					
Greater Atlantic Health Services					
Harmony Health Plan					
HIP Health Plan of New Jersey					
HMO New Jersey (US Healthcare)					
Liberty Health Plan					
Medigroup-Central, Inc.					
Medigroup, Inc. (HMO Blue)					
Medigroup-Metro, Inc.					
Medigroup-North, Inc.					
Medigroup-Shoreline Inc.					
Medigroup-South, Inc.					
Metrahealth Care Plan of New Jersey					
Oxford Health Plans					
Physician Healthcare Plan of New Jersey					
Prucare of New Jersey					
Sanus of New Jersey					
University Health Plans, Inc.					

Figure. Sample survey on HMOs given to MSNJ member-physicians.

If this approach is physician-friendly, it is not without its challenges. First Option's ability to pay a "fair and reasonable" amount to participating physicians and institutions hinges on low sales and administrative costs, an expanding market share, and restricting profits severely to the 2 to 3 percent range. Adessa warns that First Option, like other managed care organizations, must continue to be watchful over utilization rates and that physician reimbursement remains its biggest concern. Although Adessa says that the plan is about to

## *Changes in health care are creating a greater impetus for doctors to band together as equity owners of HMOs or as large groups to exert muscle in the marketplace.*

become profitable, it has reported losses for both 1994 and 1995.

"The real problem with a plan like First Option or PHPNJ is whether they can make it in a competitive market," says Dr. Lewis Sandy, a vice-president of The Robert Wood Johnson Foundation and an expert on managed care. "The factors that make these plans attractive to doctors, such as higher reimbursement scales and loose utilization controls, are the kinds of things that drive plans out of business in three or four years."

Are plans like First Option or PHPNJ the wave of the future or doomed lifeboats struggling against a powerful sea of change in medical care? A number of physician-sponsored health plans have had initial success, only to run into problems with access to capital. Is there any reason to believe First Option can be different?

Dr. Sandy believes that it is too early to evaluate physician-sponsored plans or, for that matter, the larger managed care picture in New Jersey. Although HMO enrollment in the state jumped from 450,000 to more than 1.3 million during the last ten years, the percentage of people in managed care still is relatively low. In addition, the forms of managed care remain somewhat loosely structured. "New Jersey still has many PPOs and network model HMOs that lack tight utilization controls," Dr. Sandy notes.

One thing does seem clear: Changes in health care are creating a greater impetus for doctors to band together, whether as equity owners of HMOs or as members of large groups that can exert more muscle

in the medical marketplace. Indeed, some experts, including Princeton University medical economist Professor Uwe Reinhardt, believe that ultimately physicians will regain control over health care by forming provider service networks that directly contract with employers. Through such arrangements, both employers and doctors can save money by sidestepping HMOs and splitting the fee these organizations take to manage health care.



Henry Rosin, MD, president, PHPNJ

Provider service networks already have emerged in California and Minnesota, and would receive a big boost from the Republican-sponsored Medicare plan that has been approved by Congress. Under this proposal, physician groups would be exempted from certain antitrust restraints and from various state insurance regulations that HMOs currently must follow.

In creating their own HMOs or provider networks, doctors will need access to more than capital. They will require the ability to work together as both business managers and professional colleagues. In some places, physician practice management companies already are helping to provide the business skills to establish these networks.

In New Jersey, where managed care is just taking shape, any movement in this direction seems tentative at best. Health care in the state still is being delivered within an infrastructure and culture shaped by fee-for-service medicine. But for a sense of the future we might keep a careful eye on physician-sponsored HMOs, and learn what we can from plans like First Option.

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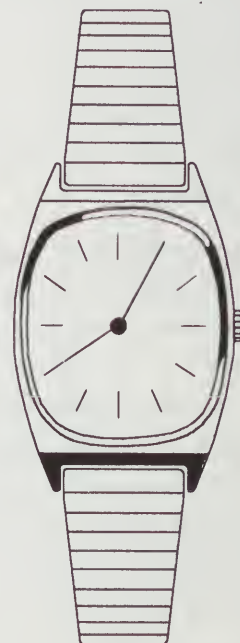
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## HCFA's Medicare mortality statistics

*Sarasavani Jayaram, MD; Ghias Moussa, MD; Anthony N. Damato, MD*

**The authors are affiliated with the Department of Medicine, Jersey City Medical Center, and Seton Hall University School of Graduate Medical Education.**

The absence of clinical severity of illness indicators in HCFA's Medicare mortality model significantly underestimates predictability of death in patients with strokes.

Since 1987, the Health Care Financing Administration (HCFA) has published statistics on the annual adjusted observed mortality rates for all hospitals that care for Medicare patients.<sup>1</sup> Mortality rates are calculated at 30, 90, and 180 days postadmission for an all causes category, eight individual conditions, and nine procedure categories. Unfortunately, HCFA's published observed-to-predicted mortality ratios have been equated with quality of care and as a measure of a hospital's performance. This practice has come under criticism because HCFA's mortality model excludes severity of illness and is garnered primarily from administrative data.<sup>2-10</sup>

In HCFA's 1993 report on Jersey City Medical Center's

Medicare mortality statistics, it was reported that the 30-day observed mortality for the condition of stroke was 104 percent above predicted; 30.2 percent versus 14.8 percent, respectively.

To determine whether this higher observed mortality was an issue of quality of care or related to severity of illness, the authors performed a case-by-case analysis of the charts with a discharge diagnosis of stroke of both survivors and nonsurvivors.

Jersey City Medical Center had a total of 909 Medicare discharges with an observed all causes 30-day mortality rate of 13.2 percent; total Medicare deaths being 118. There were 13 deaths within 30 days of admission among 43 cases of stroke, representing an observed mortality rate of 30.2 percent and an incidence of 11 percent of all Medicare deaths. Two patients died 60 and 160 days, respectively, postdischarge. Our 30-day mortality analysis compared 13 nonsurvivors to 28 survivors.

The major variables used by HCFA in computing predicted mortality were age, gender, comorbidities, and hospitalization within the preceding six months. Comorbidities included cancer, chronic cardiovas-

cular disease, chronic liver disease, chronic renal disease, chronic pulmonary disease, cerebrovascular degeneration, and diabetes mellitus. Source and type of admission that had been used in HCFA's predicted mortality model in past years were eliminated as variables in its 1993 report. In addition to the above variables, the authors compared severity of illness in survivors and nonsurvivors. Indicators used in assessing severity of illness included: Glasgow Coma Scale score on admission, presence or absence of mass effect on brain imaging, need for artificial respiration or vasopressor therapy, was do-not-resuscitate made by advance directive or requested by next of kin or designated proxy, nursing home admission, number of acute in-hospital comorbidities, and type and distribution of stroke. The latter was determined primarily from the clinical presentation, computerized axial tomography, and/or magnetic resonance imaging of the brain.

All stroke patients were under the care of board certified internists and had consultations by board certified neurologists.

Statistical analyses were done using the Chi-square



*From the case-by-case analysis, the authors concluded that the predicted mortality should have been 27.8 percent.*

method and  $t$  tested for unpaired data.

The Table lists demographic and other clinical data comparing the 13 nonsurvivors to the 28 survivors.

There were no significant differences in mean age, gender, number of comorbid illnesses, hospitalizations within the preceding six months, previous symptomatic cerebral vascular accidents, necessity of artificial respiration, or vasopressor therapy.

Significant differences between nonsurvivors and survivors were observed in the Glasgow Coma Scale score, mass effect on brain imaging, number of brain stem infarcts, number of patients made do-not-resuscitate, average number of new, acute in-hospital comorbidities, and types and location of strokes.

The average Glasgow Coma Scale score for nonsurvivors was 4.6 compared to 12.5 for survivors ( $P<0.001$ ). Only 2 of 28 survivors had scores of 6 and both of these patients remained totally unresponsive throughout their hospital course, retained their low Glasgow Coma Scale scores, were made do-not-resuscitate, and were placed in a nursing home.

Twelve of 13 nonsurvivors had brain stem infarction compared to 1 of 28 survivors

( $P<0.001$ ). This latter patient remained in a vegetative state.

Fifty percent (14 of 28) of survivors had lacunar-type infarcts compared to 1 of 13 nonsurvivors ( $P<0.001$ ). This latter patient subsequently developed a right intracerebral bleed with mass effect and died. The number of serious acute in-hospital comorbidities was 19 (average 1.3) in the nonsurvivors and 3 (average 0.10) in the survivors ( $P<0.001$ ).

In our case-by-case analysis, the authors observed several severity of illness indicators that augured a high predictability of death in the nonsurvivor group, the most important of which was the Glasgow Coma Scale score.

The Glasgow Coma Scale score has proved to be a good predictor of outcome in patients with coma of various etiologies.<sup>11-13</sup> Patients with lower scores have a higher rate of death or persistent vegetative state than those with higher scores. In a study of 226 stroke patients, Weingarten found that the average Glasgow Coma Scale score for nonsurvivors was 9.9 compared to 13.7 for survivors.<sup>12</sup> Sacco has shown that for inpatients with focal brain injury (infarct or intraparenchymal hemorrhage), a Glasgow Coma Scale score of 3 to 5

was associated with a death rate of nearly 90 percent within two weeks of onset of coma.<sup>13</sup> When applied to the nonsurvivor group with an average Glasgow Coma Scale score of 4.6, death would not have been unexpected in 12 of the 13 patients. One nonsurvivor had a Glasgow Coma Scale score of 12 that remained stable throughout the 16-day hospital course; she died of unknown causes one day postdischarge. The patient's death was not expected. Other factors that augured death in the nonsurvivor group were mass effect in 12 patients; brain stem infarction in 6 patients; and a significantly higher incidence of acute in-hospital comorbidities.

Conversely, a high Glasgow Coma Scale score, absence of mass effect, minimum number of brain stem infarcts, significantly higher number of lacunar infarcts, and significantly lower number of acute in-hospital comorbidities predicted a more favorable outcome in the survivor group. In a study of 925 consecutive patients hospitalized with acute stroke, Lefkowitz found that patients with lacunar infarcts had the lowest mortality.<sup>14</sup>

From our case-by-case analysis, the authors concluded that predicted mortality should have been 27.8 percent (12 deaths)

*The results of this study indicate that severity of illness is an important determinant of predicted mortality.*

rather than 14.8 percent (6 deaths) assigned by HCFA and, therefore, not significantly different from the observed mortality (30.2 percent).

The results of this study indicate that severity of illness is an important determinant of predicted mortality and underscores the deficiency in the HCFA mortality model. The admission Glasgow Coma Scale score, whether performed prospectively or retrospectively, has been demonstrated in other studies to be a reliable, objective predictor of outcome in stroke patients and has proved to be equally reliable in this study. As mentioned by Weingarten, the admission Glasgow Coma Scale score is treatment independent and insensitive to differences in quality of care.<sup>12</sup>

The results of this study also are in agreement with a similar case-by-case analysis the authors performed that examined significant differences between observed and predicted mortality rates for the condition of acute myocardial infarction in a Medicare patient population.<sup>14</sup> These two studies have demonstrated that by not including severity of illness indicators in the mortality model, HCFA has significantly underestimated predictability of death for at least 23 percent of the total Medicare deaths. Whether similar findings will

apply to the author's Medicare death population in other medical conditions where observed mortality significantly exceeds predicted has yet to be determined.

Almost without exception, every study of Medicare death rates that included clinical variables in its mortality model has shown that predicted death rates are significantly closer to the actual death rates than that demonstrated by the HCFA's model. A small percentage of difference remains that may reflect quality of care, unexplained severity of illness, random risk, or other unidentified factors.

Until such time as HCFA develops a Medicare mortality model that includes most or all of the clinical variables that impact on survival, it is recommended that each hospital examine those conditions that have significant variations between the observed-to-predicted mortality ratios in order to assess the quality of care delivered.

Based on severity of illness criteria, the authors calculated that the predicted Medicare mortality should have been 27.8 percent, therefore, not significantly different from the observed 30.2 percent. These results indicate that severity of illness is an important determinant of predicted mortality and underscores the deficiency in

the HCFA Medicare mortality model.

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**Table. Demographic and severity of illness data.**

	Nonsurvivors	Survivors	P Value
No. of patients	13	28	
Average age	72.4 years	72 years	NS
Males	8 (average age is 71 years)	12 (average age is 71 years)	NS
Females	5 (average age is 76 years)	16 (average age is 73 years)	NS
Average number of chronic comorbid illness	1.8	1.6	NS
Average length of hospital stay (days)	1.8	1.6	NS
Previous hospitalization in last 6 months	2	4	NS
Previous symptomatic CVA	4	7	NS
Required artificial respiration	3	1	NS
Required vasopressor therapy	1	0	NS
Admitted from nursing home	0	0	NS
Made do-not-resuscitate orders	10 (77 %)	2 (7 %)	0.001
Average Glasgow Coma Scale score	4.6	12.5	0.001
10-15	1	25	
6-8	3	1	
3-5	9	2	
Average number of acute in-hospital comorbidities	13	0.10	0.001
New in-hospital stroke	3	—	
Aspiration pneumonia	5	2	
Pulmonary edema	2	—	
Acute MI	1	—	
Acute renal failure	4	—	
Peripheral occlusion	2	—	
GI bleed	1	—	
Hypotension	1	—	
Sepsis	—	1	
Type of stroke			
Embolism	10 (76%)	10 (35%)	NS
Thrombotic	1 (7%)	1 (3.5%)	NS
Lacunar	1 (7%)	14 (50%)	0.001
Hemorrhage	1 (7%)	3 (10.7%)	NS
Brain stem infarcts	6 (46%)	1 (3.5%)	0.001
Mass effect	12 (92.3%)	1 (3.5%)	0.001

NS= Not statistically significant.

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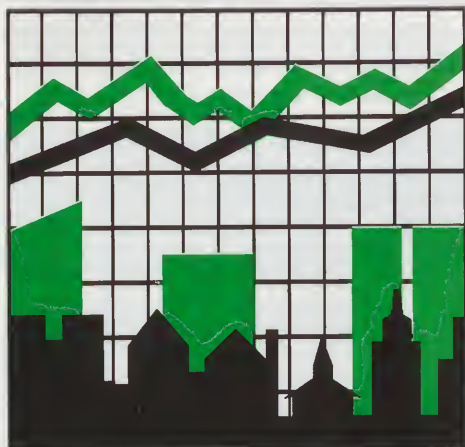
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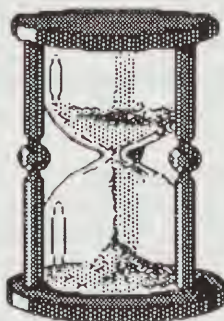


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# Limiting transesophageal echocardiography in valve endocarditis

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In recent years, echocardiography has become the primary diagnostic modality in infective endocarditis (IE). While transesophageal echocardiography (TEE) has been shown in multiple comparative studies to be superior to transthoracic echocardiography (TTE) in making this diagnosis,<sup>1-6</sup> what has not been clarified are the circumstances under which TEE should be undertaken following an initially negative TTE for suspected IE.

Although not a dangerous procedure, TEE is invasive, time-consuming, expensive, and accompanied by patient anxiety and/or discomfort. In some instances of suspected IE, such as those involving prosthetic valves, TEE may be mandatory given the difficulty of TTE diagnosis. The present study of native valve IE, where such difficulties should be appreciably less, sought to

determine the feasibility of a simpler but effective approach to this problem, utilizing repeated TTE studies in bacteremic patients, a group at relatively high risk for harboring infected heart valves.<sup>7</sup> If successful, it was felt that such an approach might be useful at institutions where 20 to 25 percent of patients referred for echocardiography appear with a possible diagnosis of IE. Performing TEE in all such patients would prove a difficult if not impossible task.

**Methods.** Over a 30-month period, diagnosed by the referring physicians, bacteremic patients with IE involving a native heart valve were evaluated by the Echocardiographic Laboratory at University Hospital. To determine the proportion of all bacteremic patients represented, a one-year monitoring of all bacteremic episodes was provided by the Department of Laboratory Medicine and Pathology.

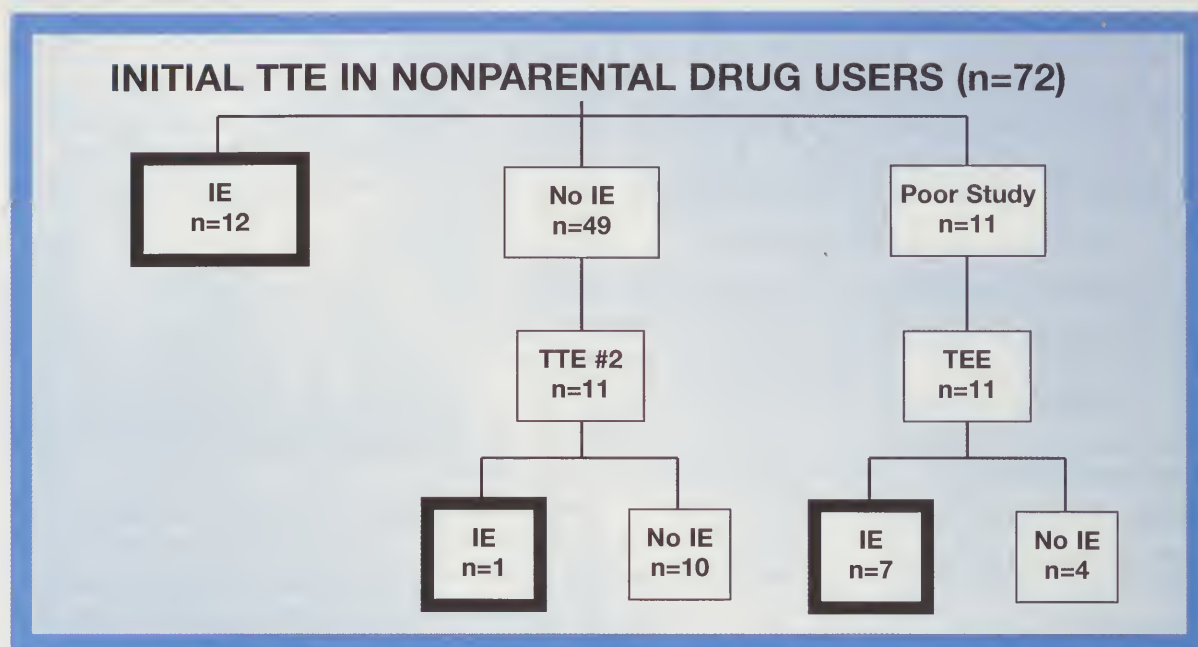
TTE was performed on all referred patients within three days of hospital admission. Criteria for a technically satisfactory two-dimensional echocardiogram included adequate visualization of all four heart valves. Color Doppler studies

were performed for the evaluation of valvular regurgitation.

The echocardiographic diagnosis of vegetations used was that of Durack.<sup>8</sup> In the presence of bacteremia this would qualify as definite diagnoses of IE by the criteria of these investigators. Additionally, we used valvular regurgitation on color Doppler, not previously recognized and of greater degree than that reported among normal subjects<sup>9,10</sup> as a criterion for IE among bacteremic patients without demonstrable vegetations on echocardiography. In patients in whom these ultrasonic criteria were not met, the diagnosis of IE was presumed in the presence of septic emboli, or on direct discovery at surgery or postmortem examination.

Patients with technically adequate initial TTEs negative for IE were requested to return in one week for a repeat study with no interruption of appropriate antibacterial therapy. TEE was suggested as an option for all bacteremic patients with poor studies, i.e. technically unsatisfactory initial TTE, technically adequate initial TTEs, that, while suggestive of IE, were not clearly diagnostic. As part of the TEE examination, a screening TTE is routinely performed in this lab-





**Figure 1.** Results of transthoracic echocardiographic studies (TTE) in bacteremic parenteral drug users suspected of having infective endocarditis (IE) including transesophageal studies (TEE) when indicated.

oratory, as was the case in this study. All echocardiographic studies were reviewed by the senior author.

Echocardiographic studies were performed on either an Interspec model CFM 750 or Apogee CX Unit. A single plane TEE probe supplied by the manufacturer was used with either unit.

Following completion of the study period, the records of patients initially admitted to the study were reviewed for confirmation of diagnosis and final outcome. Additionally, a survey of University Hospital medical records for the time in question were reviewed to uncover any cases of IE that may have been missed by the study protocol. Parenteral drug users and other

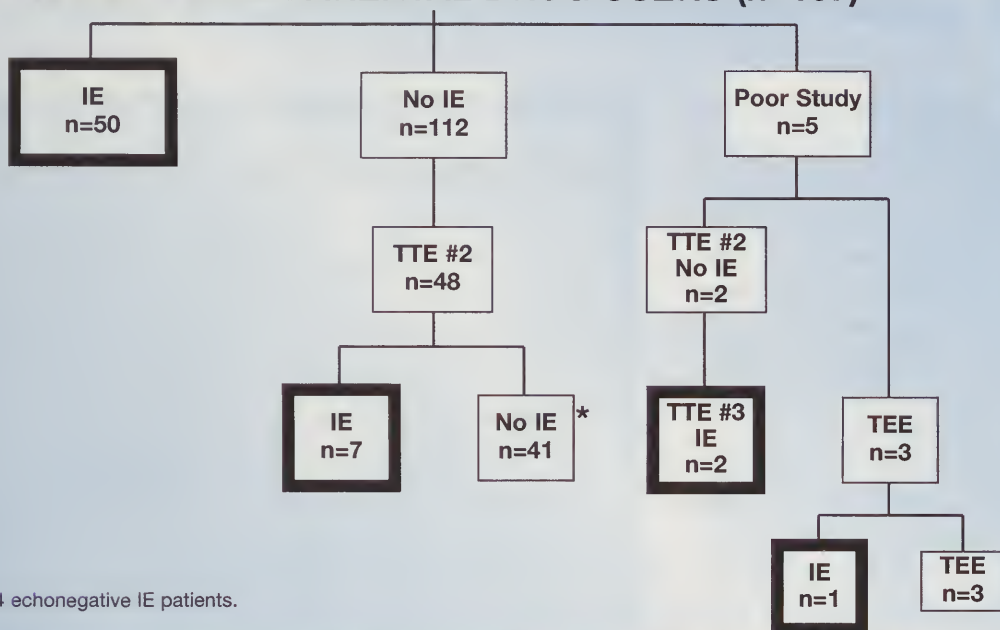
patients with suspected IE were analyzed separately.

**Results.** There were 312 patients, reportedly with bacteremia, admitted to this study. Upon chart review it was determined that 73 of these patients had not met standard criteria for bacteremia (two or more properly obtained positive blood cultures). None were subsequently determined to have IE either by our criteria or by other accepted nonechocardiographic criteria.<sup>11</sup> They were not analyzed further for the purposes of this study.

Of the remaining 239 patients, 167 patients were parenteral drug users (PDUs) with an average age of 39.9 years, and 72 patients were non-PDUs with an average age of 41.6 years. This represented

an annual rate of 96 patients referred from the average total number of 863 bacteremic patients diagnosed by our hospital each year during this period (11 percent).

Among the bacteremic patients referred for study, the diagnosis of IE was made on initial TTE in 62 patients, 50 PDUs, and 12 non-PDUs (Figures 1 and 2). Of 161 patients with technically adequate initial TTE studies and in whom IE was not demonstrated, 59 patients were returned as requested for a second look one week later. At this second TTE study, 8 patients proved positive for IE. In 16 patients, the first TTE study was either technically unsatisfactory (n = 14) or of good quality but not clearly diagnostic of IE (n = 2).

**INITIAL TTE IN PARENTAL DRUG USERS (n=167)**

**Figure 2.** Results of transthoracic echocardiographic studies (TTE) in bacteremic nonparenteral drug users suspected of having infective endocarditis (IE) including transesophageal studies when indicated.

In the latter two individuals, both PDUs, the third TTE, performed just prior to performing TEE, clearly demonstrated vegetations and the TEE study could be cancelled.

Among the remaining 14 patients, those in whom TEE was performed, 8 patients were found to have IE; only 1 of them was a PDU. The average age among these 14 patients was 51.7 years with all but 4 patients over the age of 40 years.

Although varying degrees of valvular regurgitation often were present on color Doppler imaging on initial or subsequent echocardiograms in patients with IE, in all but four patients were vegetations pre-

sent. In these four patients, the echocardiographic diagnosis of IE was made by rapidly progressing severe valvular regurgitation. Four patients with adequate TTE studies were echonegative for IE, but chest radiographs showed multiple pulmonary infiltrates typical for embolic pneumonia, as confirmed by a staff radiologist. Four patients, all PDUs, had previous episodes of endocarditis. A new episode was diagnosed by the size, shape, location, and density of vegetations as compared with previous studies. The distribution of valve involvement is indicated in the Table.

It is noteworthy that, of all those instances where an ade-

quate initial TTE study was negative and a second study was requested by our laboratory, a second study was deemed necessary by the attending physicians in only 37 percent of the cases. A detailed chart review of these patients revealed no other evidence of IE by non-echocardiographic criteria nor did a medical records survey for the period of study uncover any other cases.<sup>11</sup>

Pre-existing grossly deformed valves were not common among the group with IE: there were no clearly redundant and prolapsing myxomatous valves seen and only two individuals had underlying rheumatic heart disease, although among the 20 aortic valves involved, 1



*Over a 30-month period, bacteremic patients diagnosed by physicians with infective endocarditis involving a native heart valve were evaluated at University Hospital.*

was bicuspid and 5 showed variable degrees of sclerotic irregularities common with aging.

A higher proportion of TEEs were required for diagnosis in the nondrug user group that contained a higher proportion of older individuals with suboptimal TTE studies.

Considering the total referred patient population, TEE was ultimately required in 6 percent of bacteremic patients but gave a high yield of positive diagnoses in this selected group, accounting for 10 percent of all the individuals with IE. TTE, either performed initially or as a repeat study, provided the diagnosis in 85 percent, with 5 percent echonegative for IE.

**Discussion.** The diagnosis of bacteremia invariably requires the administration of antibiotic therapy. The critical decision in such patients involves the length and intensity of such treatment, and this must be based upon the cause of the bacteremia. In IE especially, sustained and intensive treatment usually is required for cure. Echocardiography, the diagnostic mainstay in IE, short of intraoperative or postmortem diagnosis, thus becomes the tool to determine whether the infection is seated upon the heart valves or elsewhere in the body.

**Table. Infective endocarditis and echocardiography.**

	Patients	Valves		
		Aortic	Tricuspid	Mitral
TTE #1	62 *	28	23	15
TTE #2	8	6	2	—
TTE #3	2	2	—	—
TEE	8	—	3	5
Echo-negative	4	—	—	—
24				
Totals	84	36	28	20

\*Three patients with two valves involved.

TTE = transthoracic echocardiography

TEE = transesophageal echocardiography

Studies comparing TTE to TEE in IE have shown comparative sensitivities in diagnosis ranging from 28 to 63 percent versus 90 to 100 percent, respectively.<sup>1,6</sup> Our success in diagnosing IE by TTE is higher than that of previous investigators who reported a much higher incidence of technically poor studies in patients with average ages ranging from 45 to 62 years. Our greater success was aided by the relative youth and body physique of many of our patients. Other researchers, studying PDUs with endocarditis by TTE alone, have had a high diagnostic sensitivity similar to our own.<sup>12,13</sup> A specific

important question, not addressed directly by any of these studies, is: Given an initial technically adequate TTE showing no evidence of IE, when is subsequent TEE study required?

As an extension of our previous report,<sup>7</sup> the present study was designed to expand the sample of PDUs evaluated and concurrently to evaluate a group of non-PDUs with bacteremia referred to the echocardiography laboratory with the possible diagnosis of IE. Our earlier finding of high risk of IE in preselected bacteremic patients with prior parenteral drug use has been confirmed,

*TEE can be reserved for use when a high suspicion for endocarditis persists despite negative transthoracic studies or when other circumstances mandate its performance.*

and extended to include non-PDU patients as well. However, by evaluating this in reference to the total bacteremic hospital population, the incidence of IE proves to be considerably less and in the range of 4 percent annually.

One reason for the failure of echocardiography to diagnosis IE early on may be that the size of the vegetation(s) is too small to be detected by this method. With the passage of time, the vegetation might grow in size and thus detected by TTE, as shown to be the case with repeated examinations in the present study.

**Limitations.** Some potential technical pitfalls of this study should be noted. Basing the diagnosis of IE on the appearance of valvular regurgitation alone may involve some unreliability due to subjective factors in interpretation. However, this sole criterion was relied upon in only 4 of the 80 patients diagnosed by echo as having endocarditis. In all other patients in whom valvular regurgitation developed, this was accompanied by the appearance of new vegetations.

This study was performed with monoplane TEE and theoretically multiplane TEE may have been more sensitive and may have uncovered additional cases of IE. However, no

studies comparing the two have been performed, and the most extensive study correlating TEE with surgical and autopsy results was performed with monoplane TEE and demonstrated 90 percent sensitivity.<sup>3</sup>

TEE is superior to TTE in the diagnosis of endocarditis with a negative predictive value of 100 percent for native valve endocarditis.<sup>14</sup> Should all patients with suspected IE be studied initially with TEE? In our own institution, this would present significant problems. Many patients come in our laboratory before the results of blood cultures are complete. Subjecting all referred patients with the suspicion of IE to TEE would generate possibly unjustified additional charges in addition to straining personnel and technical resources. Such considerations cannot be ignored in this cost-effective and cost-conscious era.

By not performing TEE in all subjects we may have underestimated the true number of IE cases. Furthermore, it is possible that even with short-course antibiotic therapy in some patients the development of echocardiographically visible vegetations may have been aborted. Short-course antibiotic therapy has been shown to be curative of obvious right-sided endocarditis among parenteral

drug users.<sup>15</sup> However, although such considerations may have led to an underestimation of the number of cases of endocarditis, they do not detract from the possible usefulness of this approach to management in toto.

Could we have discharged patients with IE who later developed the full-blown disease and possibly died as a result? We believe this to be unlikely. Given the seriousness of inadequately treated endocarditis, such patients would have been returned to our laboratory for re-examination. A detailed review of the hospital records of all patients initially referred plus a survey of all hospital records during this period revealed no additional cases that we might have otherwise missed in the echocardiography laboratory.

We believe that our yield of IE diagnosis by TTE and TEE represents a realistic selection of appropriate patients for this study. Subjecting all patients with suspected IE for TEE, in our opinion, would result in unnecessary expenditures of time, effort, and funds. We believe that our referring staff returned approximately one-third of their patients for a second study following an adequate initial negative TTE; this reflects their acumen in eliminating the need for additional studies of this type



## *Transesophageal echocardiography has been shown to be superior in sensitivity in the diagnosis of native valve infective endocarditis compared to transthoracic echocardiography.*

while initiating other investigations for the causes of bacteremia. Importantly, with the approach utilized here, effective antibiotic treatment was not withheld or delayed during the course of observations.

Certain caveats to diagnosing IE should be emphasized. This investigation was limited to native valve IE in a relatively young population with a high proportion of successful TTE studies. The approach suggested should hold for all similar patients, PDUs and non-PDUs alike. In the presence of pre-existing grossly deformed heart valves and prosthetic valves, TEE will be required for proper diagnosis. Similarly, in patients with poor ultrasonic windows and patients with IE established by TTE but with suspected ring abscesses or other complications, the more invasive approach may be mandatory for diagnosis or exclusion.

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# Acute acalculous cholecystitis secondary to *Candida albicans*

Bernard Peison, MD  
Barry Benisch, MD

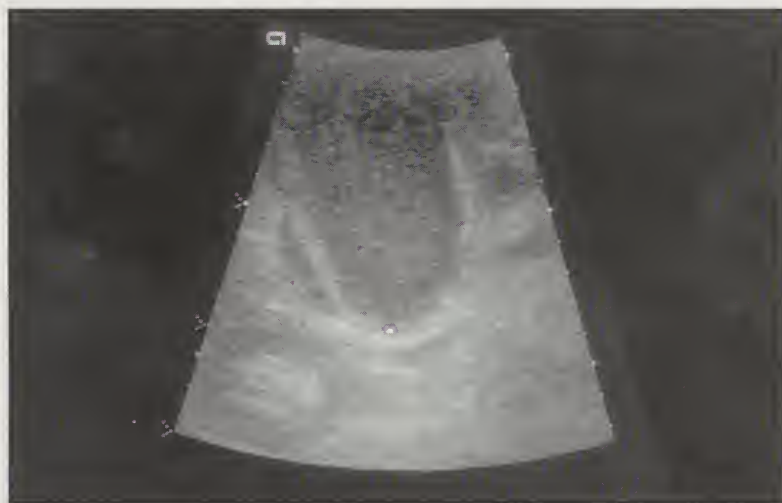
**Drs. Peison and Benisch are affiliated with the Department of Pathology, Rahway Hospital. The authors are members of the Union County component of MSNJ.**

This report demonstrates that in rare cases candidiasis can involve the gallbladder as a component of a systemic infection or as an isolated infection. Features suggestive of acute cholecystitis in a patient without cholelithiasis and with known predisposing factors for systemic candidiasis should raise the possibility of biliary tract involvement.

A 65-year-old white male was admitted to Rahway Hospital in December 1994, with acute exacerbation of chronic obstructive lung disease and left lower lobe pneumonia. He rapidly developed respiratory failure, sepsis, and hypotension. A tracheostomy was performed and the patient was placed on a ventilator. Past medical history included

quadriplegia following cervical injury in a car accident, heavy alcohol consumption, and noninsulin dependent diabetes. Two months after admission following a long stormy hospital stay while on a respirator, he developed abdominal distention with pain, tenderness, and guarding in the right upper quadrant. Abdominal ultrasound revealed an acute acalculous cholecystitis with perforation, (Figure 1) and an emergency cholecystectomy was performed. Microscopic examination of the specimen revealed acute gangrenous cholecystitis with perforation

and invasion of the wall by hyphae of *Candida albicans* (Figures 2 and 3). Cultures of blood, urine, gallbladder, and cholecystectomy wound were positive for *C. albicans*. Respiratory cultures revealed heavy growth of methicillin resistant *Staphylococcus aureus*, *Pseudomonas maltophilia*, group D enterococcus fecalis, and slight growth of *C. albicans*. The patient received multiple courses of antibiotics to treat his various infections but no antifungal therapy was instituted. The patient's hospital course was characterized by multiple episodes of respiratory



**Figure 1.** Ultrasound shows thickening of the gallbladder wall and sludge in the lumen with focal pericholecystic fluid.

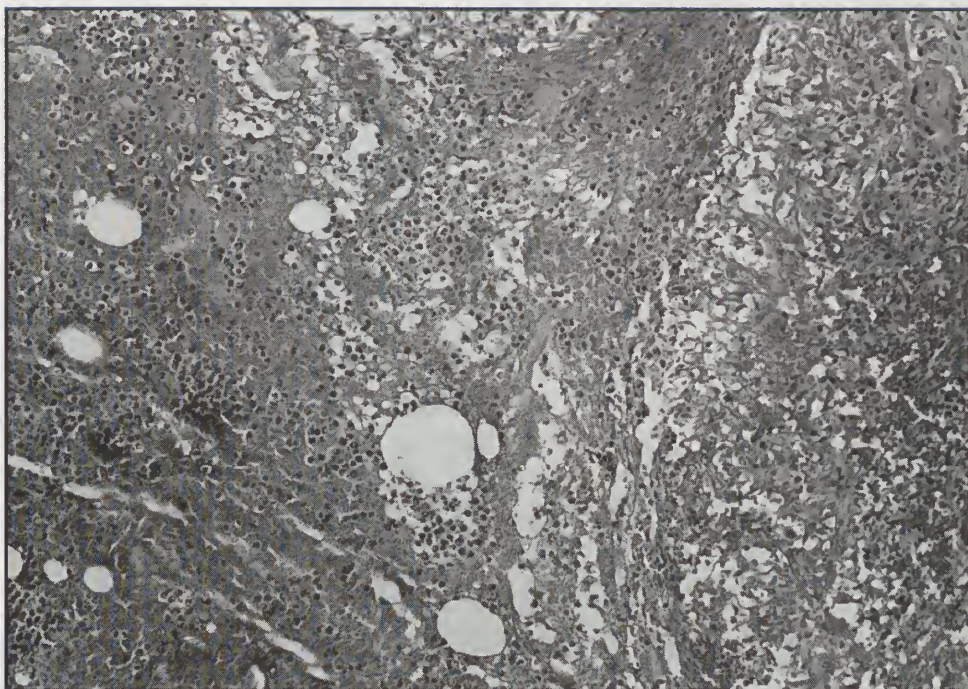


*Infections with Candida species are of increasing frequency and significance to the hospitalized patient especially for those with impaired immune systems.*

failure requiring ventilator assistance and febrile episodes. His clinical condition has improved and he remains afebrile and without a respirator; he does have residual quadriplegia and his overall condition is guarded.

Candidiasis is the most frequently encountered opportunistic fungal infection. It is caused by a variety of *Candida* species with *C. albicans* being the most frequent etiological agent. *C. albicans* is part of the normal intestinal microbial flora and infections are believed to be endogenous in origin. Under changing host conditions, fungal infections may proliferate and disseminate to remote organs. Gallbladder involvement with *C. albicans* infection, however, is a rare occurrence.

Infections with *Candida* species are of increasing frequency and significance in the



**Figure 2.** Gallbladder wall with perforation and diffuse necrosis. H&E stain x 31.

hospitalized patient, especially those with impaired immune systems. Many factors have contributed to this rise including more aggressive use of chemotherapy and immunosuppressive agents, corticosteroids, parenteral hyperalimentation, and broad spectrum antibiotics.<sup>1</sup>

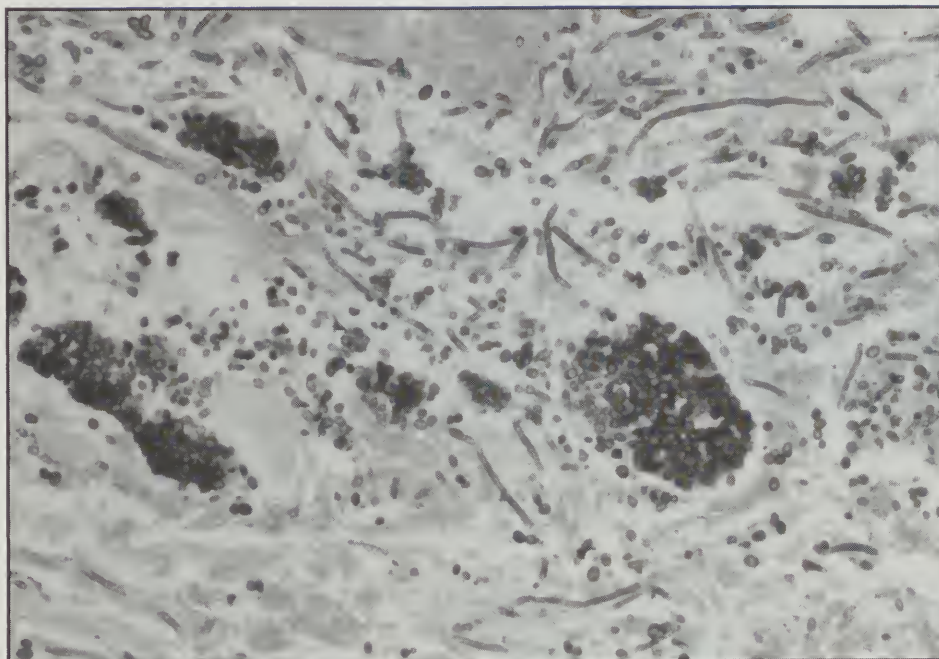
Marsh reviewed 55 patients with postoperatively developed *Candida* infection including 5 patients with *Candida* positive bile culture.<sup>2</sup>

Morris reported 9 patients found to have *Candida* species

isolated directly from the gallbladder or biliary tract during a three-year study period.<sup>3</sup> During this period, a total of 692 cholecystectomies were performed for an estimated incidence of candidal biliary tract infection of 1.3 percent. Three patients had malignancies, two patients were receiving corticosteroids, and one patient had diabetes. Three patients were receiving parenteral hyperalimentation, and all patients were receiving antibiotics at the time of diagnosis. In six patients the gallbladder was the only apparent



*Although candidiasis of almost every organ has been reported, involvement of the extrabiliary tract is rare; there were no cases in a study of 508 patients.*



**Figure 3.** Gallbladder wall with numerous hyphae of *C. albicans*. PAS stain x 78.

site of *Candida* infection. None of the patients were treated with antifungal therapy and all survived without further evidence of *Candida* infection.

Of the 22 cases of clinically important biliary tract candidiasis identified in the literature, 17 patients (77 percent) had underlying diseases or other factors thought to predispose to candidal infections including prior surgery (6 patients), hyperalimentation (5 patients), diabetes (4 patients), leukemia (3 patients), corticosteroids (2 patients), and malignancy (2 patients). Thus, only 5 patients

(23 percent) had no known risk factors for the development of *Candida* infections.

Although candidiasis of almost every organ has been reported, involvement of the extrabiliary tract is rare. In fact, not a single case was present in several autopsy studies totaling 508 patients with system candidiasis.<sup>4</sup>

Acute acalculous cholecystitis is an uncommon but very serious illness that, if undiagnosed, may lead to gallbladder perforation and death. The condition has numerous causes that result in bile stasis and

ischemia leading to inflammation and infection of the gallbladder wall. In comparison to ordinary acute cholecystitis, the acalculous variety has a higher likelihood of gangrene and perforation as well as a higher morbidity and mortality rates. Reported mortality rates have varied from 6 to 67 percent, whereas mortality from ordinary acute cholecystitis is

approximately 3 percent.<sup>5</sup> It usually occurs as a complication of another condition including trauma, sepsis, diabetes, and others. More recently, however, it has been seen with relative high frequency in healthy male patients who are older and have a high incidence of atherosclerotic vascular disease.<sup>6</sup> In contrast to calculous cholecystitis, diagnosis tends to be delayed and the disease is more advanced at the time of treatment. Therapeutic modalities that have been implicated in the etiology of acute acalculous cholecystitis include par-



*Reported mortality rates have varied from 6 to 67 percent, whereas mortality rates from ordinary acute cholecystitis is approximately 3 percent, usually as a complication of another condition.*

enteral nutrition and mechanical ventilation. In patients at risk for opportunistic infections, *C. albicans* is a ready pathogen and the gallbladder a rare but recognized site for both colonization and established infection. It is of interest to note that the risk factors for acalculous cholecystitis are the same as those for gallbladder candidiasis, each being a recognized complication of critical illness.

Microscopic examination of the gallbladder revealed the absence of calculi and the wall to be diffusely necrotic with perforation and massive infiltration by hyphae of *Candida*, which leads to the conclusion that the perforation was due to the candidemia and not the absence of calculi. The pathogenesis of gallbladder candidiasis is not well understood but believed to result from colonization of the gastrointestinal tract by *Candida*. *Candida* species are part of the normal gastrointestinal flora. Invasive disease, usually caused by *C. albicans* but can be caused by other species, occurs when normal bacterial microflora is suppressed with the breakdown of normal mucosal barriers. The

observation of candidemia and candiduria in a normal subject, who drank a suspension containing a large amount of *Candida*, supports the hypothesis that the gastrointestinal tract is the source of dissemination.<sup>7</sup> Biliary tree involvement with *C. albicans* is a rare occurrence. The cases reported in the literature were secondary to surgery or invasive procedures performed in the biliary system or the alimentary tract. The case being reported is unique, for the lack of an invasive procedure involving the biliary system before the gallbladder invasion with *C. albicans*. The predisposing factors for candidiasis in the patient are unknown, but may include the multiple courses of antibiotics as well as his diabetes.

Features suggestive of acute cholecystitis in a patient without cholelithiasis and with known predisposing factors for systemic candidiasis, should raise the possibility of biliary tract involvement. Although this condition represents a diagnostic challenge, treatment is highly effective with most reported patients having completely recovered. Patients with uncomplicated acute *Candida* chole-

cystitis are cured by surgery without specific antifungal therapy.

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Irene J. Beyth, MS, RD  
Anna Baratta, MS, RD, CNSD

*Current research supports the hypothesis that carbohydrates can influence and modify mood and behavior in some individuals.*

The authors are affiliated with Newark Beth Israel Medical Center, Department of Food and Nutrition Services, Newark.

Can a plate of pasta affect your mood? Why do women with premenstrual syndrome (PMS) crave sweets? Newspaper and magazine articles suggest the consumption of chocolate can make your spirits soar and a plate of pasta can help you feel warm, happy, and more relaxed.

Meal composition has been shown to influence behavior and food intake. There are some groups of individuals that appear to be carbohydrate (CHO) sensitive, but the etiology is as yet unknown. For example, individuals who suffer from seasonal affective disorder (SAD), a mild depression during the winter months, have been found to report CHO craving.

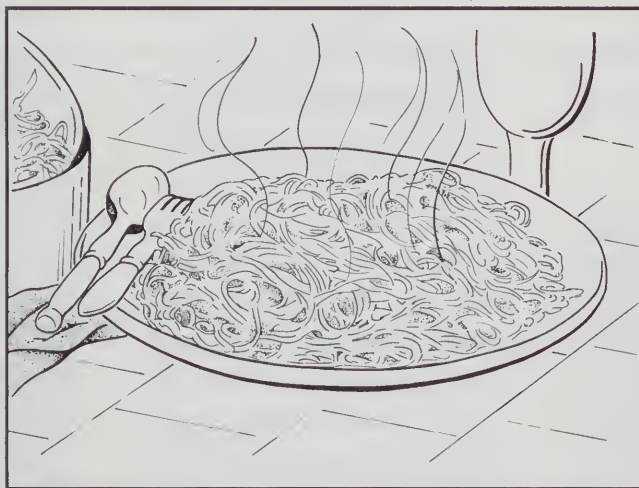
Patients diagnosed with SAD expressed improvement in mood following the ingestion of protein-poor, CHO-rich test meals. Cravings for CHO also decreased when patients were exposed to bright lights, causing them to reset their biological clocks.<sup>1,2</sup>

Excess CHO intake also has

sumption of a CHO-rich, protein-poor evening test meal was found to improve the depression, tension, anger, sadness, fatigue, alertness, and calmness scores among patients with PMS. No effect of the test meal was noted during the follicular phase in the sufferers or in the control subjects during either phase. This increase in CHO craving may lead PMS subjects to overeat in an attempt to improve their moods.

Lieberman identified two groups associated with snacking behavior, CHO and non-CHO cravers.<sup>2</sup> When mood was assessed before and two hours after the consumption of a high

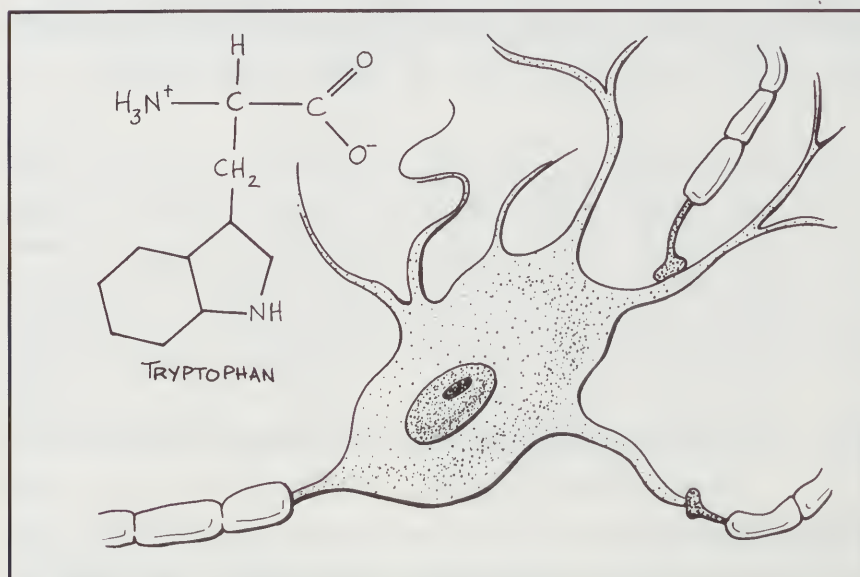
CHO lunch, two groups of obese individuals expressed varied results. Non-CHO cravers reported feeling less alert and sleepy with an increase in fatigue and an increase in depression. CHO cravers reported feeling little or no change in energy level and



been related to premenstrual depression. In a study by Wurtman, patients claiming to suffer from severe PMS found calorie intake, during the late luteal phase, increased by 24 percent from meals and by 43 percent from snacks.<sup>3</sup> The con-



*Data suggest that dieting reduces the availability of tryptophan for 5-HT synthesis and that women are more vulnerable to the effects of lowered 5-HT.*



assessed themselves as feeling less depressed than before the meal.

Researchers have been examining the relationship between CHO and serotonin levels in obesity, eating disorders, mood, pain management, and regulation of macronutrient intake.<sup>4</sup> Much attention has been given to the influence of CHO intake on serotonin (5-HT) levels. Physiologically, the synthesis and release of serotonin is dependent on the uptake of tryptophan across the blood-brain barrier. Tryptophan shares a common carrier with five other large neutral amino acids (LNAA): valine, isoleucine,

leucine, tyrosine, and phenylalanine). The carriers are saturable and competitive.<sup>5</sup>

The amount of tryptophan available to the brain is dependent on several factors. The ingestion of a high CHO meal causes tryptophan levels to remain stable as insulin promotes the peripheral uptake of most amino acids into tissues and skeletal muscle. As a result, the ratio of tryptophan to the other LNAAs rises and the amount of tryptophan available to the brain increases. The increased amounts of tryptophan result in an increase in the synthesis and release of serotonin.<sup>4-8</sup>

Some people express a definite need to snack on high CHO goods.<sup>7,9,10</sup> In some individuals, it appears that these needs are related to brain serotonin levels. Blum studied 96 healthy obese and non-obese males and females.<sup>6</sup> The results showed that the majority of obese subjects preferred CHO to protein. The 5-HT levels were lower in obese males and all lean/obese males that craved CHO. As

all of the women craved CHOs, it was difficult to determine whether the lowered 5-HT levels were due to weight or food preferences.<sup>9</sup> Wurtman suggested that subjects with low brain 5-HT try to compensate by eating high CHO or sweet foods and, as a consequence, gain weight.<sup>7,9</sup>

Dieting has been associated with a reduction of plasma tryptophan. Anderson placed male and female patients on a low-calorie diet.<sup>9</sup> Although both groups lost similar percentages of weight, the women had a larger reduction in plasma tryptophan levels. The data suggest that dieting reduces the availability of tryptophan for 5-HT

## *Dieting has been associated with a reduction of plasma tryptophan. Anderson placed males and females on a low-calorie diet; the women had a larger reduction in plasma tryptophan.*

synthesis and that women appear more vulnerable to the effects and consequences of lowered 5-HT. Anderson further suggests that "these changes might contribute to the development of clinical eating disorders in vulnerable individuals."<sup>9</sup>

Use of dietary manipulation and its effect on serotonin for chronic pain management has been considered. Serotonin is a neurotransmitter that has been implicated in the pain response.<sup>11</sup> It appears that as the depletion or blockage of serotonin occurs due to chronic pain or some medications, there is a heightened sensation of pain. Lack of adequate tryptophan in the diet also can alter pain sensitivity. Augmentation of serotonin will reduce the perception of pain. Since administration of L-tryptophan has been found to pose potential health risks, Haze suggested dietary manipulation as a possible method of providing adequate tryptophan to patients.<sup>11</sup> Although several studies have shown that dietary manipulation failed to show a significant improvement in chronic pain patients, Haze felt that the diets were not calculated specifically for individual needs

and that patients had not been told of the importance in adhering to the diet.

The current research supports the hypothesis that CHOs can influence and modify mood and behavior in some individuals. Clinicians could utilize the data to help CHO-craving dieters to modify food patterns to include those foods and help aid in compliance. If further research confirms Anderson's findings that dieting can lower serum 5-HT, then perhaps weight reduction diets could be modified to provide foods high in tryptophan to alleviate some of the symptoms of low 5-HT levels. PMS sufferers also seem to benefit from high CHO foods. It remains to be proved whether this is related to low 5-HT levels, B-endorphins, or opiates.

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## MANAGED CANCER CARE. A BLUEPRINT FOR DISCUSSION

Ismail Kazem, MD

*It is possible to develop a treatment protocol for individual patients based on the type of cancer and its stage.*

Dr. Kazem is director, Radiation Oncology, Gesinger Clinic, Danville, PA. Dr. Kazem is a member of the Mercer County component of MSNJ and a member of the MSNJ Council on Communications.

Cancer is the second leading cause of death in the United States. The financial burdens of cancer are great to each individual and to society as a whole. The impact of cancer as a disease on the managed care delivery system is very important.

Cancer management envisions a program that includes screening, early detection, diagnosis and staging, treatment, rehabilitation, psychosocial and nutritional support, pain management, and terminal care. To be a quality- and cost-effective system, the integrated resources of a multidisciplinary cancer program should be linked to a network of primary care physicians and community-based support teams. To support the role of primary care physicians as

gatekeepers for referral of cancer patients at an early stage, primary care physicians should be trained to identify high-risk patients, to recognize early signs and symptoms of cancer, and to perform annual cancer checkups on patients and record findings. Patients suspected of having cancer should be referred to a cancer center. Alternatively, within the primary care network, it also is possible to have a focused cancer screening and early detection office as a satellite of a cancer center or as a part of a family practice.

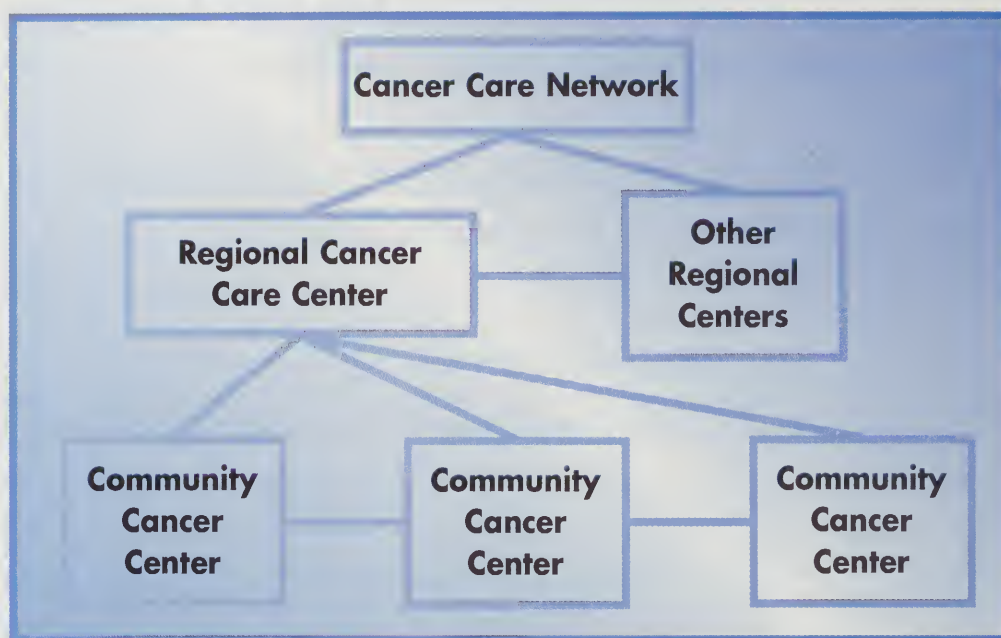
It may be argued that screening and early detection would add to the cost of health care, thus defeating the purpose of managed care. This argument is easily rebutted as the cost of treating an early cancer is estimated to be one-third to one-half of the cost of treating advanced diseases. In addition, the probability of the curative outcome of treating early cancer ranges between 60 to 90 percent, whereas advanced cancer can only be palliated. If the loss of productivity and quality of life is factored into the equation, it

becomes harder to refute the value and cost savings of early detection and early treatment.

Cancer is a group of diseases that differ in natural history and behavior depending on the cell type and primary site. In spite of the diversity of the different types of cancer and allowing for individual variation in tumor-host interactions, most cancers are reasonably predictable. Stage for stage and cell type for cell type, the oncology community has developed a pattern of care for most types of cancer that is acceptable as well as offering the best expected outcome. This pattern of care is arrived at through clinical trials and consensus panels sponsored by the National Cancer Institute.

Thus it is possible to develop a treatment protocol for individual patients based on the type of cancer and its stage. It also is possible to estimate the total cost of such a treatment protocol. Basically, a patient with a newly diagnosed cancer will undergo clinical examination, workup consisting of laboratory tests, and diagnostic





**Figure 1.** New Jersey statewide cancer program—networking.

*Structure and coordination.* The goals of a cancer institute should reach beyond its walls and boundaries. The mission of a cancer institute should be to reduce cancer incidence and mortality, as well as to improve the quality of life of cancer survivors. The

imaging and biopsy to confirm cell type and other biological characteristics. This is followed by a single modality treatment: surgery, radiation therapy, or chemotherapy, or multiple modality treatment consisting of one or more treatments, depending on the appropriate plan or protocol.

A cancer center or a cancer program can contract with a managed care carrier to provide cancer management based on a prepaid cost projection, as a packaged global service or as negotiated fee for service.

New Jersey is one of top ten states in cancer incidence and mortality. Recognizing this fact, the New Jersey State Health Plan contains a separate chapter on cancer. Although dated, the chap-

ter contains basic information and proposals that still are valid, yet new realities in New Jersey strongly suggest the need for some rethinking.

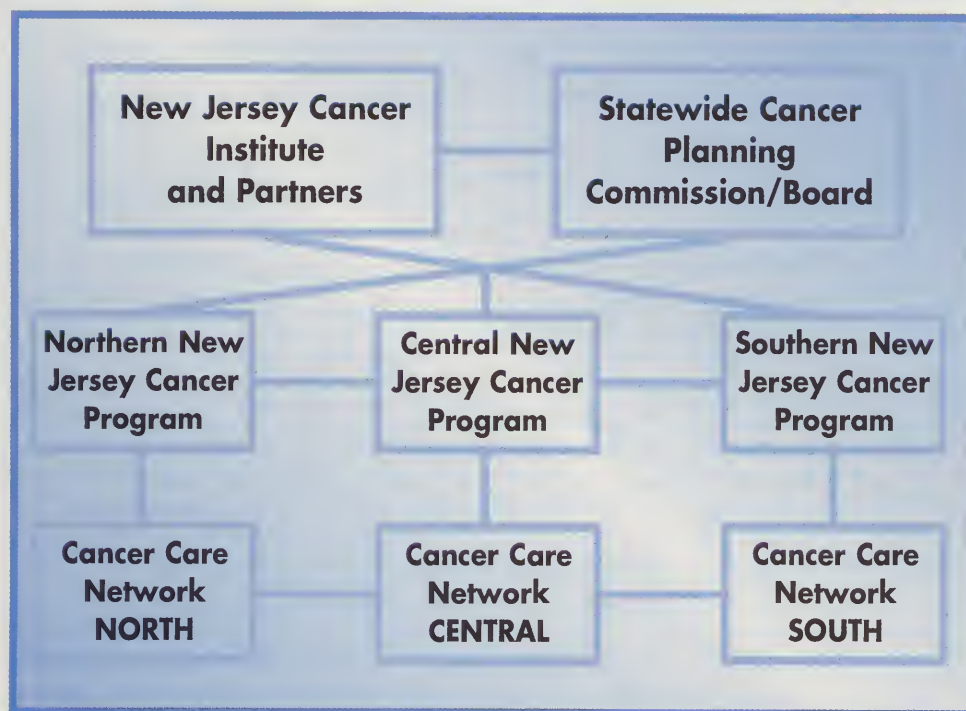
Of these new realities, the most significant are: the proliferation of managed care coverage; the invasion of New Jersey by out-of-state cancer centers and university hospital satellites; and the birth and growth of the Cancer Institute of New Jersey.

There is a unique window of opportunity for New Jersey to launch a statewide cancer program to fulfill the goals of quality care, universal coverage, and cost containment. The Cancer Institute of New Jersey can play a central role in such a program.

Cancer Institute of New Jersey can be a unifying force and a catalyst for a state of New Jersey cancer care program. There are many existing resources in New Jersey for cancer management. These resources can be integrated, networked, coordinated, streamlined, trimmed, and/or expanded according to state-wide needs. The Cancer Institute of New Jersey should take the initiative to propose a New Jersey cancer planning commission under a mandate from the governor. The planning commissioner should include representatives of partners and affiliates of cancer activities in the state. This would include representatives of the New Jersey State Department of Health, the New Jersey Comm-

ission on Cancer Research, the American Cancer Society, MSNJ, the New Jersey Hospital Association, and others. The planning commission would propose a plan for comprehensive cancer care coverage for each of three regions. Within this plan, existing resources should be optimally utilized; underutilization, overutilization, and substandard facilities would be identified and appropriately corrected (Figures 1 and 2).

**Consensus formulation.** A panel of experts representing all aspects of the cancer management team can prepare guidelines for state-of-the-art patient care for different cancer types and stages. These guidelines, prepared according to nationally accepted patterns of care and consensus recommendations, should be flexible and should be accepted for standard coverage and for estimation of cost of negotiated managed care policies. Clinical trials and investigational treatments should be specified separately with identifiable criteria and sources of financing.



**Figure 2.** New Jersey statewide cancer program organization.

*Peer review and outcome analysis.* To maintain the quality of care, standardized documentation and database entries to a statewide tumor registry are required.

This type of system will help in auditing the standard of care, evaluating different methods of diagnosis and treatment, and providing data for epidemiology, assessment of needs, and feedback for future planning and research for all cancer patients.

*Research and development.* It is estimated that 40 percent of New Jersey cancer patients seek treatment out of state. In addition, the proliferation of out-of-state cancer treatment satellites in New Jersey drains in-state financial resources.

If a New Jersey state cancer program is developed and implemented to provide quality cancer care, New Jerseyans will not need to seek treatment away from home. Out-of-state satellites will not have the incentive to operate under a New Jersey managed care plan. This will result in an increase in available patients for participation in clinical trials. It also would encourage pharmaceutical companies to spend research dollars within the state. This has the potential to enhance the prospects of the Cancer Institute of New Jersey in achieving the ultimate goal of reducing cancer incidence and mortality.



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# COMMENTARY

## New violence institute extends UMDNJ tradition of service to New Jerseyans

*Stanley S. Bergen, Jr,  
MD, President*

At the start of the new year, the University of Medicine and Dentistry of New Jersey (UMDNJ) launched an ambitious, institution-wide endeavor to combat the leading public health problem of our time—violence.

The effort will be coordinated by an institute charged with targeting violence through a multifaceted program of research, education, and treatment. Led by the Foundation of UMDNJ and a task force of UMDNJ specialists, the venture will expand and diversify existing programs in such areas as child sexual abuse, substance abuse, and conflict resolution among adolescents.

Violence in our society is clearly reaching new heights, evidenced daily in our newspapers and television and radio news programs. One national poll showed that an increasing number of teens are carrying weapons; a recent UMDNJ/Eagleton Poll revealed that more than 60 percent of New Jerseyans now feel more threatened by violence than five years ago and some 30 percent now feel more threatened in their own neighborhoods.

The establishment of a violence institute was announced on January 24, 1996, at UMDNJ's annual University Day program, kicking off the University's 26th year. It represents UMDNJ's continuing determination to address society's ills, particularly as they threaten New Jerseyans.

Since its inception in 1970, UMDNJ has been committed to providing the citizens of New Jersey with diverse opportunities in health sciences education and access to state-of-the-art health care programs. Early on, the institution gained a national reputation as a pioneer in urban medicine, creating effective programs to fight tuberculosis (TB), childhood lead poisoning, infant mortality, and other ills devastating the city of Newark, home to UMDNJ's first campus. Subsequently, as new campuses emerged in central and southern New Jersey, diverse communities throughout the state benefitted from a tremendous array of programs in health care, education, and social services.

NJM



## COMMENTARY

Throughout its history, UMDNJ has shown the vision and flexibility to adapt to change and, indeed, to stay in front of it. It was among the first—and possibly the first—in the nation to treat children for AIDS. And UMDNJ is in the forefront of efforts to control resurging TB.

UMDNJ's response to the health care reform revolution clearly shows its agility in responding to change. Two years ago UMDNJ formed the nation's first statewide university-based managed care network, University Health Care (UHC).

UHC combines the technology and expertise of advanced teaching hospitals and medical school faculty with community-based medicine to provide affordable, high-quality health care. In December, UHC allied with New York Hospital Care Network, Inc., the managed care network of New York Hospital and Cornell University Medical College, to form the nation's first bi-state, university-based managed care network. Those enrolled in either system have access to both networks—14,000 total practitioners—whether they work or live in either state.

The formation of UHC followed dramatic academic changes instituted by UMDNJ to meet the changing demands

of the health care environment. All three of UMDNJ's medical schools—New Jersey Medical School, Robert Wood Johnson Medical School, and the School of Osteopathic Medicine—revised curricula to emphasize primary care and preventive medicine throughout the educational process. In addition, medical students were, and are, encouraged to pursue residencies in primary-care specialties and to consider service in underserved urban and rural areas. Last year, more than 47 per-

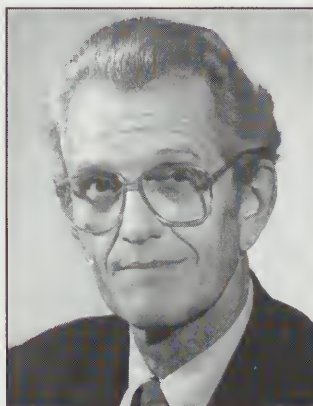
cent of UMDNJ's medical graduates entered primary care residencies against a national average of about 28 percent.

Measures like developing a violence institute and creating a statewide managed care network are the latest examples of UMDNJ's response to the needs of

the citizens of our state. In fact, they are part of a continuum of efforts over 25 years. Highlights include:

- UMDNJ-New Jersey Medical School and UMDNJ-Robert Wood Johnson Medical School both rank among the nation's leaders in minority enrollment and retention and New Jersey Medical School has one of only a handful of Hispanic Centers of Excellence in the country.

- The New Jersey Medical School National Tuberculosis Center at UMDNJ leads the fight against drug-resistant TB.



*Stanley S. Bergen, Jr., MD*



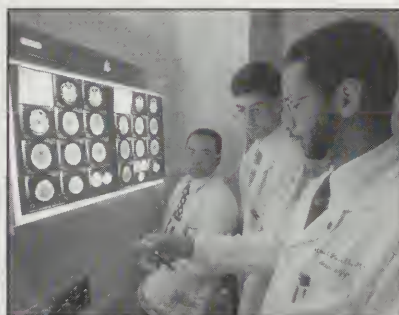
UMDNJ's reputation as a national leader in recruitment and retention of minority students is a tribute to the efforts of faculty members like Dr. Maria Soto-Greene, director of the Hispanic Center of Excellence.

- The Cancer Institute of New Jersey, a collaboration between UMDNJ and several affiliates, is on track to become the state's first federally designated comprehensive cancer center.

- UMDNJ-New Jersey Medical School is designated by the National Institutes of Health as a vanguard site for the Women's Wellness Initiative to study health issues in older women.

- UMDNJ-New Jersey Medical School is a national resource for pediatric AIDS research.

- UMDNJ's clinicians and scientists are conducting research programs to advance the treatment of cancer, heart disease, stroke, trauma, diabetes, TB, neurological disorders and genetic diseases, and others.



*UMDNJ physicians like Dr. Artiss Powell, associate professor of neurology at UMDNJ-Robert Wood Johnson Medical School, have garnered national recognition for their research.*

UMDNJ was created by the Medical and Dental Education Act of 1970, which envisioned a statewide institution providing New Jerseyans with educational opportunities in the health sciences and access to high levels of health care.

Today, some 4,300 medical, dental, nursing, graduate, and allied health students are enrolled in UMDNJ's seven schools, located at campuses in Newark, Piscataway/New Brunswick, Camden, and Stratford. Nearly 1,000 students graduate annually.

UMDNJ also operates a major teaching hospital in Newark and community mental health centers in Newark and Piscataway. UMDNJ reaches New Jerseyans statewide via a network of more than 100 health care and educational affiliates.

Last year, UMDNJ's anniversary observance capped 25 years of growth unparalleled in the history of health sciences education. By virtually every measure—the quality of educational programs, the reach of health care services, the scope of research efforts, and the range of community services—UMDNJ has emerged as one of the nation's finest academic health centers.

## COMMENTARY

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## PHYSICIANS AND NURSE PRACTITIONERS: CAN THEY WORK TOGETHER?

Carol Anne Weiss, RN

*Nurse practitioner programs emphasize physical assessment, diagnosis, and treatment, and promote wellness and health.*

If physicians are to survive capitation, they must transform their traditional office and hospital-based practices from cottage industries into well-run businesses. This will require physicians to delve more deeply into understanding payment standards and reimbursement schedules. In the new health care system, managed care companies increasingly will insist on preapproval of routine medical decisions. These administrative hassles will only increase physicians already large amounts of paperwork and expand telephone consultation time. As a result, physicians will be able to spend even less time in direct patient care; coupled with managed care's increasing demands to provide a wider array of preventive services, the frustration level of physicians is compounded ad infinitum. Many patients already feel physicians do not spend enough time with them.

Enter the nurse practitioner. The nurse practitioner concept originated in an effort to provide health care services to underserved populations. Nurse practitioner programs emphasize physical assessment, diagnosis, and treatment. The basic philosophy is promotion of wellness and good health through education of patients and their families.

If physicians are to survive capitation, they must transform their traditional office and hospital-based practices from cottage industries into well-run businesses. This will require physicians to delve more deeply into understanding payment standards and reim-

Lisa Nogy, RN; Andrew Kunish, MD

*The collaborative practice agreement is a foundation securing independent and interdependent decision making.*

As health care professionals move forward in this ever-changing arena of health care, nurse practitioners and physicians must respectfully collaborate and take advantage of their complementary roles to achieve high-quality health care.

Managed care and capitation reward providers for keeping patients healthy. Health promotion and prevention always have been the purview of the nurse practitioner. When physicians and nurse practitioners work as a team of interdependent, mutually respected professionals, the nurse practitioner's expertise in the area of health teaching, obtaining health histories and physical examinations, and treating minor illnesses frees the physician to care for the more acutely ill. The role of the nurse practitioner should not overlap but rather augment the role of the physician. Additionally, the role of the physician is to oversee the management of the nurse practitioner's caseload. It is imperative that the nurse practitioner and the physician jointly develop a collaborative proactive agreement, including protocols that reflect mutually agreed upon guidelines and standards of care. The collaborative practice agreement is an integral foundation securing the relationship that includes both



### Weiss

A nurse practitioner is taught to assess a patient and to evaluate a patient's environmental, nutritional, and psychosocial milieu. A nurse practitioner also devotes considerable time in consultation with a patient to review a patient's condition and treatment regimen.

A nurse practitioner's primary function is patient education. By spending more time with a patient, a nurse practitioner enables a patient to understand the need to take responsibility and how that impacts health.

Some of the functions performed by a nurse practitioner overlap the work of a physician, such as a physical examination, diagnosis and treatment of acute episodic illness, treatment of simple chronic disease states, and health maintenance. But the inclusion of a nurse practitioner should be viewed as an enhancement of the services offered and not a substitute for physicians. The prescriptive privileges granted to a nurse practitioner in New Jersey should be viewed as an additional resource for a comprehensive medical practice. While a nurse practitioner has independent licensure and certification standards set by the state Board of Nursing, it is imperative that a nurse practitioner emphasizes the cooperative nature of the practice. It is only through teamwork with physicians that a nurse practitioner can realize the full potential of the profession.

At this juncture in the health system restructuring, a nurse practitioner can provide a welcome safety valve for physicians in all settings who are struggling to meet the additional pressures of managed care. A nurse practitioner also offers the additional advantage of insuring that patients receive optimum care and advice. A nurse practitioner should not be viewed as an adversary to a physician, but as a partner in a newly emerging health system. Together they can support each other while providing quality.

### Nogy/Kunish

independent and interdependent decision making. Nurse practitioners function within their own scope of practice and consult or refer complicated cases deviating from the established guidelines to the expertise of the collaborating physician.

The nurse practitioner is invaluable in many settings, particularly the outpatient areas, which serves for many patients as the first point of contact with the health care system. Often patients have been the victims of a chronic cycle of fragmented health care, multiple emergency room visits, physician hopping,

*The prescriptive privileges granted to a nurse practitioner should be viewed as an additional resource for a comprehensive medical practice.*

economic hardship, and self-neglect. The role of the nurse practitioner in this setting is to ensure the delivery of continuous comprehensive health care, improve accessibility, and enhance compliance. Noncompliance is one of the reasons patients end up in a more costly setting. The addition of a nurse practitioner into a medical practice to assist physicians who already are struggling to see more patients in the same amount of time should be viewed as a positive aspect.

For the few who remain skeptical about the nurse practitioner and view the role as an infringement on the physician's authority and autonomy, have no fear. Physicians and nurse practitioners are patient advocates and share the common goal of wanting good for all patients. In this partnership each assumes responsibility for the specific aspects of the patient's needs.

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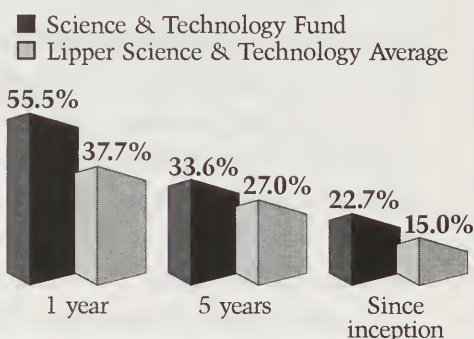
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# editorial guidelines

## Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an in-depth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

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## Specifications

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The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

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- Date: April 12, 1996  
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Speaker: Jacob I. Sage, MD
- Date: April 19, 1996  
Topic: "Osteoporosis: New treatment"  
Speaker: Avedis K. Khachadurian, MD
- Date: April 26, 1996  
Topic: "Non-malignant/Malignant Pain Management"  
Speaker: Elizabeth J. Narcessian, MD
- Date: May 3, 1996  
Topic: "Anticoagulation Therapy and Laboratory Monitoring"  
Speaker: Yak Arkel, MD
- Date: May 10, 1996  
Topic: "Alternative Medicine"  
Speaker: Kumunda Reddy, MD
- Date: May 17, 1996  
Topic: "GERD in the Elderly"  
Speaker: Charles P. Bongiorno, MD
- Date: May 24, 1996  
No Lecture—Memorial Day Weekend

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**Bernard R. Chaitman, M.D.**

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# calendar

## APRIL '96

### **QUINLAN RETROSPECTIVE**

**APRIL 12-13, 1996**

Hyatt Regency, Princeton  
(Shore Memorial Hospital)

### **CARE OF FEMALE PATIENTS**

**APRIL 18-19, 1996**

Ocean Place Hilton, Long Branch  
(UMDNJ)

### **MANAGED CARE**

**APRIL 26, 1996**

RWJ Medical School, New Brunswick  
(MIIX and UMDNJ)

### **TRANSFUSION MEDICINE**

**APRIL 17, 1996**

General Hospital Center at Passaic  
Passaic (AMNJ)

### **RADIOLOGICAL SOCIETY OF NJ**

**APRIL 23, 1996**

The Hyatt Regency, New Brunswick  
(AMNJ)

### **MSNJ ANNUAL MEETING**

**MAY 1-4, 1996**

Trump Taj Mahal Casino/Resort  
Atlantic City (MSNJ)

### **STRATEGIES FOR SUCCESS**

**APRIL 17, 1996**

MSNJ Headquarters, Lawrenceville  
(AMNJ)

### **PACEMAKER MEETING**

**APRIL 24, 1996**

Sheraton at Woodbridge Place, Iselin  
(AMNJ)

### **ASSESSMENT OF THE ELDERLY**

**MAY 1, 1996**

St. Mary's Hospital, Passaic  
(AMNJ)

### **MRI OF THE SPINE**

**APRIL 17, 1996**

Cooper Hospital, Camden  
(AMNJ)

### **MANAGED CARE**

**APRIL 24, 1996**

MIIX, Lawrenceville  
(MIIX and UMDNJ)

### **PROSTATE CANCER**

**MAY 1, 1996**

Corning Laboratories, Teterboro  
(AMNJ)

### **ESTROGEN REPLACEMENT THERAPY**

**APRIL 17, 1996**

St. Mary's Hospital, Passaic (AMNJ)

### **W.P. BURPEAU AWARD DINNER**

**APRIL 24, 1996**

The Manor, West Orange (AMNJ)

### **STUDIES OF ABDOMINAL EMERGENCIES**

**MAY 1, 1996**

General Hosp. Center, Passaic (AMNJ)

### **FAMILY MEDICINE SERIES**

**APRIL 17, 1996**

UMDNJ, Camden (Cooper Hospital)

### **ENDOCRINE ROUNDS**

**APRIL 24, 1996**

University Hospital, Newark (AMNJ)

### **ENDOCRINE ROUNDS**

**MAY 1, 1996**

University Hospital, Newark (AMNJ)

### **ENDOCRINE ROUNDS**

**APRIL 17, 1996**

UMDNJ-University Hospital, Newark  
(AMNJ)

### **MEDICAL GRAND ROUNDS**

**APRIL 24, 1996**

Veterans Administration Medical Center  
East Orange (AMNJ)

### **MEDICAL GRAND ROUNDS**

**MAY 1, 1996**

Veterans Administration Medical Center,  
East Orange (AMNJ)

### **MEDICAL GRAND ROUNDS**

**APRIL 17, 1996**

VA Medical Center, East Orange  
(AMNJ)

### **VISITING LECTURE**

**APRIL 25, 1996**

St. Barnabas Med. Ctr., Livingston  
(AMNJ)

### **MEDICAL ETHICS**

**MAY 1, 1996**

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Atlantic City (AMNJ)

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### APRIL 1996

APRIL 3rd

#### The Calcium Antagonist Controversy

*Franz Messerli, M.D.*

Clinical Professor of Medicine

Tulane University School of Medicine, Director,  
Hypertension Laboratory, Ochsner Clinic,  
New Orleans, LA

#### Racial Differences in the Treatment of Hypertension

*Barry J. Materson, M.D.*

Professor of Medicine

University of Miami School of Medicine, University  
of Miami Medical Group, Miami, FL

APRIL 10th

#### The Thrombosis Prone Patient: Abnormalities of Protein C and Factor V

*John C. Hoak, M.D.*

Former Director, Division of Blood Diseases and  
Resources, National Heart, Lung and Blood  
Institute (NHLBI), Clinical Professor of Medicine,  
Uniformed Services University of the Health  
Sciences, Consultant to Walter Reed Army  
Hospital, Bethesda, MD

APRIL 17th

#### Treatment of HIV and Related Opportunistic Infections

*Martin S. Hirsch, M.D.*

Professor of Medicine

Harvard Medical School, Head, Infectious Diseases  
Unit, Massachusetts General Hospital, Boston, MA

### APRIL 1996

APRIL 24th

#### Diagnosis and Treatment of Hormone Secreting Pituitary Tumors

*Lawrence A. Frohman, M.D.*

Edmund F. Foley Professor and Head Department  
of Medicine, University of Illinois at Chicago,  
Chicago, IL

### MAY 1996

MAY 1st

#### New Concepts in the Management of Atrial Fibrillation

*Peter L. Friedman, M.D., Ph.D.*

Associate Professor of Medicine

Co-Director, Cardiac Arrhythmic Service and  
Clinical Electrophysiology Laboratory,  
Cardiovascular Division, Brigham and Women's  
Hospital, Boston, MA

MAY 8th

#### Advances in the Treatment of NIDDM

*Alan J. Garber, M.D., Ph.D.*

Professor of Medicine, Biochemistry and Cell  
Biology, Baylor College of Medicine,  
Houston, TX

MAY 15th

#### The Kidney as a Window to Cardiovascular Morbidity and Mortality

*Leopoldo Raij, M.D.*

Professor of Medicine

University of Minnesota School of Medicine, Chief,  
Nephrology/Hypertension, Veterans Affairs  
Medical Center, Minneapolis, MN

### MAY 1996

MAY 22nd

#### Allergic Rhinitis Pharmacology: New Directions

*Lanny Rosenwasser, M.D.*

Professor of Medicine

University of Colorado Health Science Center,  
Head, Allergy Division, National Jewish Center for  
Immunology and Respiratory Medicine,  
Denver, CO

MAY 29th

No Grand Rounds

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## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

APRIL 3, 1996

#### Hypertension: Understanding the Controversies in the Treatment of Hypertension

*Franz Messerli, M.D., Barry J. Materson, M.D.*

APRIL 17, 1996

#### Treatment of HIV and Related Opportunistic Infections

*Martin S. Hirsch, M.D.*

MAY 8, 1996

#### Prevention and Treatment of Complications of Diabetes Mellitus

*Alan J. Garber, M.D., Ph.D., Harry Gottlieb, M.D.*

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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# calendar

## MAY and JUNE '96

### **HIGH RISK /CRITICAL CARE SURGERY**

**MAY 8, 1996**

St. Mary's Hospital, Passaic (AMNJ)

### **INTERHOSPITAL ENDOCRINE ROUNDS**

**MAY 8, 1996**

University Hospital, Newark (AMNJ)

### **HOSPITAL MEDICAL GRAND ROUNDS**

**MAY 8, 1996**

VA Medical Center, East Orange  
(AMNJ)

### **DERMATOLOGY MEETING**

**MAY 14, 1996**

Schering Corporation, Kenilworth  
(Dermatological Society of NJ)

### **INTENSIVE BIOETHICS**

**MAY 10-11, 1996**

Sheraton Tara, Parsippany  
(NJ Health Decisions)

### **NEWER CARDIAC DRUGS**

**MAY 15, 1996**

St. Mary's Hospital, Passaic  
(AMNJ)

### **ENDOCRINE ROUNDS**

**MAY 15, 1996**

University Hospital, Newark (AMNJ)

### **HOSPITAL MEDICAL GRAND ROUNDS**

**MAY 15, 1996**

VA Medical Center, East Orange (AMNJ)

### **HEAD & NECK & RADIATION ONCOLOGY**

**MAY 22, 1996**

The Manor, West Orange (AMNJ)

### **NEPHROTOXICITY OF COMMON DRUGS**

**MAY 22, 1996**

St. Mary's Hospital, Passaic (AMNJ)

### **INTERHOSPITAL ENDOCRINE ROUNDS**

**MAY 22, 1996**

University Hospital, Newark  
(AMNJ)

### **MEDICAL GRAND ROUNDS**

**MAY 22, 1996**

VA Medical Center, East Orange  
(AMNJ)

### **ALLERGY MANAGEMENT**

**MAY 29, 1996**

General Hospital Center at Passaic  
(AMNJ)

### **ENDOCRINE ROUNDS**

**MAY 29, 1996**

UMDNJ-University Hospital, Newark  
(AMNJ)

### **MEDICAL GRAND ROUNDS**

**MAY 29, 1996**

VA Medical Center, East Orange (AMNJ)

### **MULTIPLE ANTIBIOTIC- RESISTANT BACTERIA**

**JUNE 5, 1996**

St. Mary's Hospital, Passaic (AMNJ)

### **FRONTIERS IN BIOMEDICINE: CD44**

**JUNE 5, 1996**

Corning Laboratories, Teterboro (AMNJ)

### **DIAGNOSIS AND TREATMENT: HEADACHE**

**JUNE 5, 1996**

General Hospital Center, Passaic (AMNJ)

### **GASTROENTEROLOGICAL/ GASTROINTESTINAL/ENDOSCOPY**

**JUNE 5, 1996**

The Manor, West Orange  
(AMNJ)

### **OB/GYN SOCIETY MEETING**

**JUNE 7-8, 1996**

Trump Plaza Hotel & Casino,  
Atlantic City (AMNJ)

### **NONHODGKIN'S LYMPHOMAS**

**JUNE 12, 1996**

St. Mary's Hospital, Passaic  
(AMNJ)

### **TYPE II DIABETES MELLITUS**

**JUNE 19, 1996**

General Hospital Center at Passaic  
(AMNJ)

### **EMERGENCY PHYSICIANS**

**JUNE 19-20, 1996**

Trump Plaza, Atlantic City (AMNJ)

### **ANNUAL MEETING: FAMILY PHYSICIANS**

**JUNE 26-29, 1996**

Bally's Park Place, Atlantic City (AMNJ)



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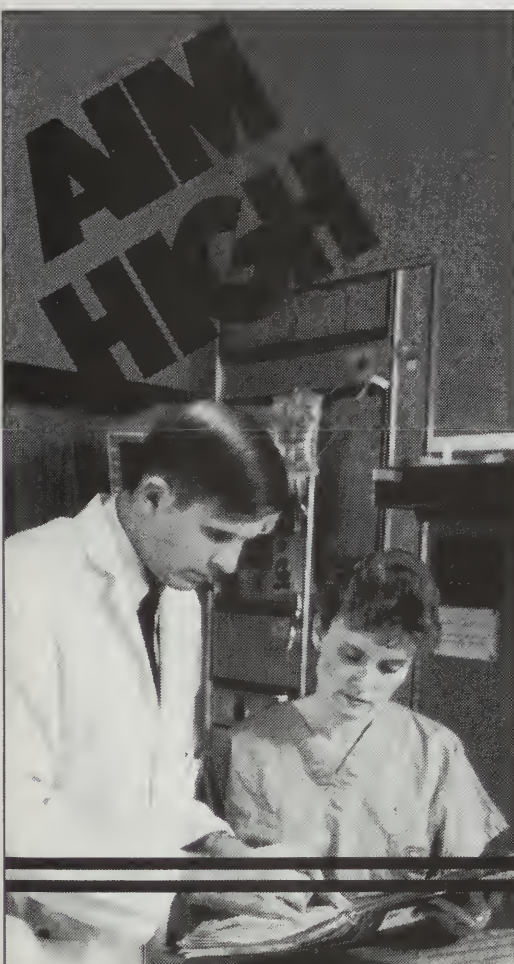
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continued from page 72

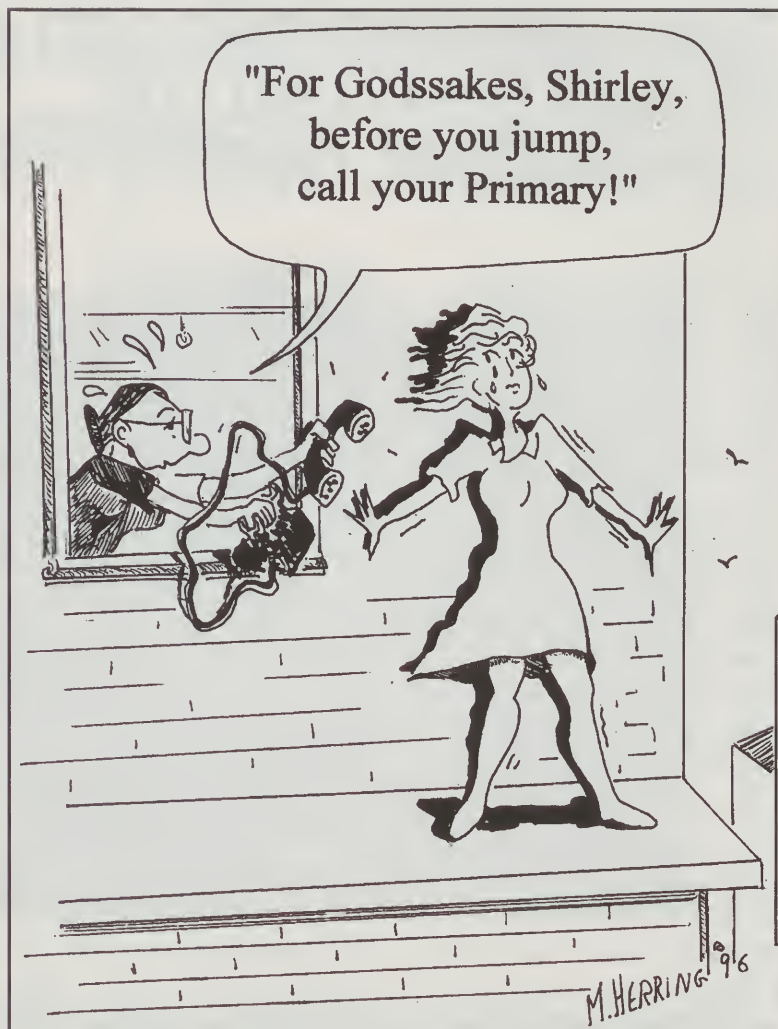
### Election of AMA candidates

The AMA delegation from MSNJ announced its strong support for the re-election of Palma E. Formica, MD, to the AMA Board of Trustees. Dr. Formica served as MSNJ president in 1988-1989. In addition, the delegation strongly supports the election of Joseph N. Micale, MD, to the Council on Medical Education and the election of Robert J. Weierman, MD, as a candidate for chair of the Organized Medical Staff Section.



### Dr. D'Elia remembered

William J. D'Elia, MD, of Spring Lake, passed away on January 31, 1996, at the age of 83. We will remember Dr. D'Elia for his many years with MSNJ; serving as its president in 1972 and as a member of the House of Delegates. Dr. D'Elia practiced in Monmouth and Ocean Counties, as an orthopedic surgeon. Dr. D'Elia was medical director and chief of staff at Jersey Shore Medical Center; he served on the hospital's Board of Governors. An AMA member, Dr. D'Elia was past-president of the Monmouth County Medical Society and of the New Jersey Orthopedic Society.



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is affiliated with Kennedy Memorial Hospital-University Medical Center, Stratford.

### Informational and policy publications available through MSNJ

The MSNJ Committee on Biomedical Ethics recently developed DNR orders and advance directives. The DNR orders include "Policy for Physicians"; "Policy for EMS Personnel"; and a patient compliance form. The advance directive includes: "Terms You Should Understand"; "Instruction Directive"; "Durable Power of Attorney for Health Care"; and "Checklist: Questions To Ask

Yourself." For copies, contact Barbara Mihalik, at MSNJ, telephone 609/896-1766, extension 263.

The following publications also are available: *MSNJ Policy Compendium*; *The Physicians' Desk Guide to Law & Medicine*; *Medical Policies & OSHA Manual*; and *MSNJ Membership Directory*. To order these publications, call MSNJ, telephone 609/896-1766.





## MSNJ ANNUAL MEETING HIGHLIGHTS MANAGED CARE AND BIOMEDICAL ETHICS

From May 1 through May 4, 1996, MSNJ will host its 230th Annual Meeting at the Trump Taj Mahal Casino/Resort in Atlantic City. Highlighting the meeting will be The Academy of Medicine of New Jersey lecture on May 1 with Commissioner Fishman; the Golden Merit Award Ceremony on May 2; the JEMPAC Political Forum and wine and cheese reception on May 2; and an educational program on HIV in New Jersey. Delegates from New Jersey will discuss proposed resolutions on health care policy, managed care, and reimbursement. In addition to the working programs, a reception honoring outgoing President Louis L. Keeler, MD, will be held on May 2 and an inaugural dinner honoring the incoming president, Anthony P. Caggiano, Jr, MD, will be held on May 3. For registration information, call MSNJ, 609/896-1766.



AMNJ honoree

Donald K. Brief, MD, a member of the Essex County component of MSNJ, is the recipient of the Edward J. Ill Award, presented by The Academy of Medicine of New Jersey to a physician for distinguished service as a leader in the medical profession and in the community. Dr. Brief will be honored at a dinner on May 29, at the Chanticleer in Short Hills. For ticket information, call 609/275-1911.



ACS volunteer of the year

Louis G. Fares, II, MD, is the American Cancer Society-Mercer Unit volunteer of the year. A MSNJ member, Dr. Fares is a vascular and general surgeon and is affiliated with St. Francis Medical Center, Robert Wood Johnson University Hospital, Hamilton, and Helene Fuld Medical Center. A diplomate of the American Board of Surgery, Dr. Fares also is a fellow of the American College of Surgery.

### MSNJ offers testimony on electronic data interchange

Paul Weber, MSNJ director, Finance and Administration, recently offered testimony before the Senate Health Committee on bills pertaining to electronic data interchange (EDI) technology. Weber pushed for tighter security protocols; extension of the tax credit; specific time frames with an independent mediator for the dispute process; implementation deadlines of EDI standards; and standard enrollment and claim forms. Also highlighted were: advantages of an EDI network over "smart cards" and a private, nonprofit corporation to operate the network. Weber also expressed concerns over the EDI Interchange Technology Development Fund and automated transition incentive fee. The Internet, Weber noted, could be more feasible than designing a new system.

*continued on page 71*

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New Jersey MEDICINE

## newsWATCH

State Health Commissioner Len Fishman chalked up impressive appearances before the Senate and Assembly Appropriations Committees last month. Nominally set up as informational sessions to allow members of key legislative committees to determine the wisdom of decisions reflected in the governor's budget, the hearings have become annual spring rites where state cabinet heads either shine, as Mr. Fishman has for three years running, or grow dim, as was infamously the case with a previous commissioner of health.

The state's first nonphysician health commissioner, Mr. Fishman used the hearings as a forum for articulating his broader vision of the 1,500-person, \$416.5 million Department of Health (DOH). The requested budget is down 1.8 percent from last year's spending level, while staffing would climb 1.0 percent.

"We no longer are the Department of Hospital Rate Setting we were a decade ago," the commissioner jauntily observed. "Rather, we are evolving into managers of information—information used to shape public policy, to direct resources where they'll be most effective, and to hold parties accountable."

This informational approach drives DOH's emerging regulatory strategy toward HMOs and other managed care entities. As gatherers, compilers, interpreters, and disseminators of information, DOH seeks to be in a position to steer the market toward those health plans that most effectively meet the health policy

imperatives of broad access, affordable cost, and high quality—and responsiveness to direction from regulators.

In other words, DOH seeks to assemble and generate data that will tend to induce purchasers and consumers to gravitate toward those health plans that appear most sensitive to Trenton's concerns.

Even more notably, though, the 1996 hearings marked the last stage appearance of the "old" DOH. **Governor Christie Whitman** has proposed merging diverse programs involving services for the elderly within a restyled "Department of Health and Senior Services" under Mr. Fishman's direction.

The Commissioner has cast this change as an effort to create a new "one-stop-shopping" system for the elderly, who now purportedly careen from one office to another in the pursuit of assistance for which they are eligible. The new approach has been labeled "Easy Access Single Entry," or "NJ-EASE."

To succeed, NJ-EASE will require a smooth transition into the new "DHS2" of programs currently housed in the Department of Human Services and Department of Community Affairs. Effective resistance could emerge, especially from long-time Medicaid officials in Human Services.

**On April 22 aides to Mr. Fishman and to Insurance Commissioner Elizabeth Randall released the latest set of proposed regulations covering HMOs. A July deadline for submitting formal comments on the proposal was anticipated.** The newest revisions increase the requirements for funds that HMOs must deposit in state accounts. The new draft also permits provider organizations to become risk-bearing entities, and



it specifies a framework for mandatory disclosure of payment incentives for providers, including so-called adverse incentives to withhold care.

**Although tobacco, AIDS, and spot high cancer rates have been garnering most of the New Jersey media attention focused on public health controversies lately, family violence could re-emerge as the lodestone public health issue at any time. The AMA notes that more years of potential life are lost to violence than to heart disease, cancer, and stroke combined. The years-lost measure assumes a normal life expectancy of 70 years.**

A history of family violence is strongly linked to violent acts by youth. Researchers also find associations between violence and poverty, substance abuse, the presence of firearms in the home, and exposure to violence on television.

Meanwhile, media attention to the thorny issue of whether to permit clean needle exchanges among injection drug users in controlled situations has obscured other AIDS-related conundrums, such as whether to test HIV-positive pregnant women for resistance to zidovudine or for viral load, two strong predictors of HIV transmission to the baby.

AIDS officials and clinicians also are looking to develop a strategy to facilitate access to expensive protease inhibitors and to create "carve-out" or special programs for HIV-positive adults and children covered by HMOs under Medicaid.

On a dissonant note, the Easter Seal Society of New Jersey encountered volleys of flak from tobacco control and cancer experts who were half-amused, half-

enraged by a cigar party Easter Seal fundraiser. The fire may not soon die down.

Lastly on the public health front, DOH has taken over not only elderly programs but also the medical waste program, previously run by the Department of Environmental Protection. Under relaxed procedures, state inspectors no longer will require physicians and other generators of small amounts of medical waste to maintain logs, and inspection cycles and penalties will be loosened.

**Consider price-fixing by drug companies. Federal Trade Commission investigators reportedly are inquiring into possible practices by 22 pharmaceutical research and manufacturing firms—including New Jersey-based giants Johnson & Johnson, Merck, and Bristol-Myers Squibb—that force independent pharmacies to pay higher prices than chain drug stores.**

If a multicompany pricing conspiracy is proved, a class action suit filed by pharmacies could pick up steam. The pharmacies find it difficult to compete with HMOs and hospitals that obtain large discounts.

**Officials at the state Board of Medical Examiners are gloating over results of data released by the Public Citizen Health Research Group, which centered on physicians disciplined by state boards—and that included the obligatory opprobrium about "bad doctors" and the boards that shield them. The New Jersey spin is that the Garden State took action against a higher proportion of licensees than did any other large state. Feel safer?**

**Neil E. Weisfeld**



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*Health Care in the Garden State*

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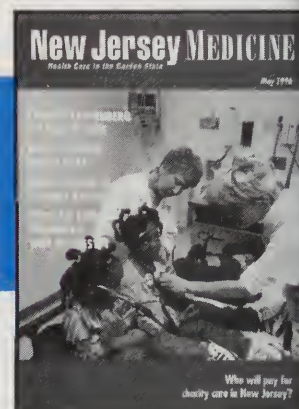
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The Garden State faces the dilemma of excess demand on hospitals that treat the uninsured. As we grapple with this issue, the problem continues. Cover © Conrad Gloos



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# New Jersey MEDICINE

## Joint ventures

The article by Alma Saravia, "Cooperative activity among health care providers in New Jersey" (*NJ MED* 92:790-792, 1995) rightfully draws attention to proposed antitrust-related legislation by state lawmakers affecting health care entities and providers, and some of the potential, attendant legal concerns. Although the extant body of antitrust law does not completely turn off the spigot of joint ventures and cooperative action in the health realm, the structure and functioning of actions of a cooperative nature are delimited by law.

An interesting point to consider, and one of a potentially problematic nature, is that managed competition and joint ventures appear to be rapidly growing currents in the health field, albeit ones that are moving in opposite directions. The mantra of managed competition is competition. The theoretical main pillar of support upholding the foundation of managed competition is that managed care plans will compete with one another, thus achieving cost containment. Skeptics abound, however; and are fearful that such plans, in practice, may collude to raise prices, rather than compete to lower them. Joint ventures, mergers, and consolidation may be desirable to health professionals and entities as representing the best-available mechanisms for

increasing profitability as the result of increased market share and greater cost efficiency. If it comes to pass, however, that cooperative activity results in a managed care environment increasingly dominated by plans and entities that are fewer and fewer in number and larger and larger in size, the few, remaining mammoth entities may be less inclined to compete and more likely to raise prices. The potentially anticompetitive ramifications of New Jersey Senate Bill 1402 must be recognized, and should not be given short shrift.

New Jersey physicians also should be alert to federal antitrust strictures. The federal government's "Statement of Enforcement Policy and Analytical Principles" offers guidance to doctors by describing antitrust safety zones. One of the statements creates antitrust safety zones for exclusive as well as nonexclusive physician network joint ventures. Physicians wishing to navigate the labyrinth of antitrust law without running afoul of germane restrictions and requirements must be aware of such laws at the state and federal levels.

Senate Bill 1402 should not be construed as a green light for providers to engage in joint ventures. It is merely one legal force twisting and shaping the ever-evolving body of health care antitrust law.

Leo Uzych, JD, MPH

## Allergy testing

Dr. Bielory's article on asthma (*NJ MED* 93:158-162, 1996) states that skin testing for allergy is superior to RAST, which quantitatively measures pollen specific antigens in the blood. This provides flexibility in formulating treatment solutions not available from skin testing. Using the criteria and cut off points established by Fadal and Nalebuff, RAST diagnosis is safer and more accurate, since it establishes classes of sensitivity so that mixtures of desensitizing antigens can be tailored for each antigen. Allergists ran into trouble with RAST because the original criteria established by Johanssen were too high and resulted in too many false negatives. Attempts to quantitate sensitivity by size of skin wheal according to different concentrations of allergen have been tried successfully, but require too many expensive intradermal injections. Scratch and skin testing risk anaphylaxis, a danger totally eliminated by RAST properly used.

The most expeditious way to screen food allergies is to remove all grains, egg, and milk products from the diet for about a month—about 80 percent of food allergies. After all, a piece of bread contains grain, egg, milk, and yeast.

Charles Harris, MD

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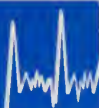
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## James S. Todd, MD

Executive Vice-President  
American Medical  
Association

The AMA announced the retirement of executive vice-president James S. Todd, MD. A Ridgewood resident, Dr. Todd served the AMA since 1985, as senior deputy executive vice-president, acting executive vice-president, Board of Trustees member, and commissioner to JCAHO. At the state level, Dr. Todd was a trustee and chair of the MSNJ Board of Trustees and chair of the New Jersey delegation to the AMA House of Delegates. Dr. Todd also was awarded the Edward J. Ill Distinguished Physician Award by The Academy of Medicine of New Jersey, and the Distinguished Service Award by the New Jersey Hospital Association.

## Home care awards

**The honorees of the 1996 Physician of the Year were selected for their outstanding efforts to facilitate independent living for the elderly and disabled, care of AIDS patients, support of chronically ill patients and their families, and provide comfort care for the terminally ill through the use of home health care services. This year's honorees are:**

## PHPNJ operates statewide

The Physician Healthcare Plan of New Jersey (PHPNJ), the first physician-owned and directed managed care organization, is in 21 counties. Spearheaded by MSNJ member Henry D. Rosin, MD, PHPNJ's focus is strong doctor-patient relationships as a model for delivering high-quality health care. PHPNJ has won

Alexander Liberman, MD, Atlantic; Peter Scivoletti, MD, Bergen; Mary F. Campagnolo, MD, Burlington; Janet M. Lieto, DO, Camden; Warren F. MacDonald, MD, Cape May; Robert Fazzaro, MD, Cumberland; Gnanan Sunderman, MD, Essex; Churchill Lyon Blakey, MD, Gloucester; Mitchell J. Mutterperl, MD, Hudson; Paul Madura, MD, Hunterdon; Scott Lee Adler, MD, Mercer; Harry Collins, MD, Middlesex; Steven Berkowitz, MD, Monmouth; Maria Costea-Misthos, MD, Morris; Helio J. Malinverni, MD,

## Making the headlines

**Donald C. Huston, DO, William V. Harrer, MD, and Gary R. Brickner, MD**, MSNJ members, were appointed by the governor to the state Board of Medical Examiners. **Eileen McGinnis** succeeds Jane M. Kenny as the chief of the Office of Policy and Planning for the New Jersey State Department of Health. **Joseph E. Gonzalez, Jr** has been named as president of the New Jersey Business & Industry Association. **Pat Regenber**, director of the Health Sciences Library at The Mountainside Hospital, received the New Jersey Hospital Librarian of the Year award. **Harriet E. Derman** was named as Governor Whitman's chief counsel. **Carol A. Fasano**, director of Christ Hospital School of Nursing, was named New Jersey Hospital Administrator of the Year. **Robert A. Carabelli, MD**, was appointed clinical assistant professor, Department of Physical Medicine and Rehabilitation, UMDNJ-Robert Wood Johnson Medical School.



Mary F. Campagnolo, MD  
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Ocean; Steven Kanengiser, MD, Passaic; Uday S. Uthaman, MD, Salem; Amy Shute, MD, Somerset; Craig R. Buggeln, MD, Sussex; Stephen Grelecki, MD, Union; Leonard A. Feitell, MD, Warren.

the endorsement of MSNJ and the New Jersey Association of Osteopathic Physicians and Surgeons. The Health Care Payers Coalition of New Jersey, which manages health care benefits for a group of business, labor, and trade organizations, has joined with PHPNJ to offer top-rate health care to 75,000 employees and union members. "Our collabora-

tion with PHPNJ will have significant and positive implications for our members and for the people of New Jersey. We envision this as a very unique, hands-on relationship between a coalition of health care consumers and a care delivery system managed by physicians," said George R. Laufenberg.

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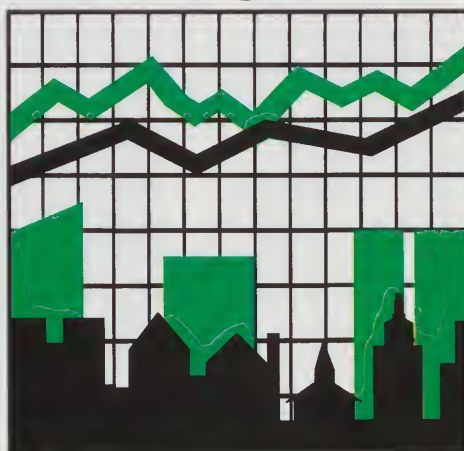
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continued from page 10



*Volunteers like Hope Henes update and tap the Clearinghouse's computer database.*

## New Jersey Self-Help Clearinghouse

The New Jersey Self-Help Clearinghouse, established in 1981, maintains information on self-help groups in New Jersey. With a computer database of information on over 4,000 groups in the Garden State and 800 national organizations and one-of-a-kind groups, physicians, health care professionals, and the public may access this information by calling 1-800/FOR-MASH (1-800/367-6274). The internet e-mail address is: NJSHC@bc.cybernex.net. The Clearinghouse also encourages the development of new groups and can assist individuals in starting a new self-help group.



*Howard Holtz, MD*

## Domestic violence advocate

Howard Holtz, MD, was presented with the Domestic Violence Advocate of the Year award by the New Jersey Coalition for Battered Women at ceremonies in Princeton. Barbara M. Price, executive director of the Coalition, praised Dr. Holtz for making "an important contribution in advocacy for victims of domestic violence." Dr. Holtz

is director of the Domestic Violence Prevention at Saint Barnabas Medical Center, in Livingston, which trains health professionals and students to recognize, treat, and counsel victims and refers victims to supportive services. Dr. Holtz also is a member of MSNJ and of the Essex County Medical Society, and associate chair of the Department of Medicine at Saint Barnabas Medical Center.

## Poison information

Governor Christine Whitman joined with the New Jersey Poison Information and Education System (NJPIES) to get the word out about where to turn in a poisoning emergency. "The most important thing that people should know is the poison center telephone," says Steven Marcus, MD, executive director of NJPIES. NJPIES can be accessed for education materials and information concerning toxicological problems and poison situations. Staffed with specialists, NJPIES is accessible 24 hours a day, 7 days a week, by calling 1-800/POISON-1 (1-800/764-7661).




*Governor  
Christie Whitman*

## Legal defense fund

First Amendment Rights Fund for Every Physician (FARFEP) is a fund that protects a physician's First Amendment rights. FARFEP believes physicians should be able to speak the truth about any medical issue without the fear of a lawsuit. The fund was created to assist any physician who is being sued for writing or speaking the truth on any medical issue. For information, contact FARFEP, PO Box 1968, Santa Fe, NM 87504, 505/982-7797.

## Diabetes services

Governor Whitman signed into law legislation that requires health insurers to provide coverage for diabetes self-management education provided by recognized dietitians, certified diabetes educators, and pharmacists who have completed a diabetes management course recognized by the New Jersey Board of Pharmacy. Health insurers also are required to provide coverage for certain diabetes equipment and services. This law is the result of efforts by the American Diabetes Association and the New Jersey Pharmacists Association. 

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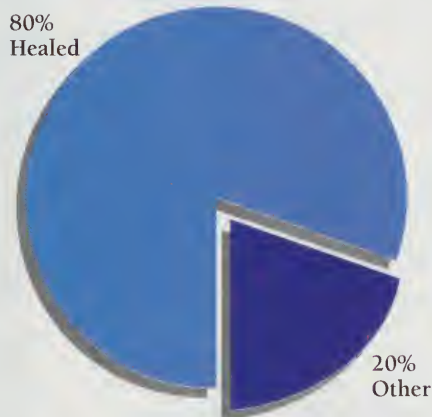
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# The rights of every man and woman in the United States

The conflict between personal and societal rights in this country is as old as the country itself. In this month's *New Jersey MEDICINE*, Dr. Donald Louria presents a modern version of this conflict, between the individual's right to privacy and the community's right to know, adjudicated by the United States Supreme Court. The issue: testing student athletes for drugs.

The Vernonia, Oregon school board, with the approval of the local citizenry, instituted testing of these students for mind-altering drugs for several reasons. It hoped to curb the perceived epidemic of use and abuse of these substances. It expected to give additional protection to these athletes and their contacts during contests. And it hoped that athletes as "roles models" would influence other students toward a more moderate and rewarding lifestyle.

The privacy controversy relates directly to the Fourth Amendment of the Constitution, and the separation of "unreasonable search" from "probable cause"—the crux of many decisions and legal interpretations, and a subject foreign to my intellect and training. So

I shall not play the devil's, or any other, advocate. The Supreme Court, as noted, and by a six-to-three decision, upheld the right of the school board to test the student athletes.

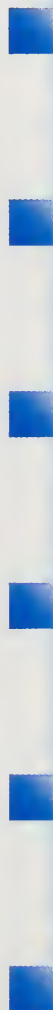
The ninth circuit had ruled that the Vernonia policy both violated the Fourth Amendment and contravened Article I-9 of the Oregon constitution. The Supreme Court vacated the judgment and remanded the case to the Court of Appeals. Justice Scalia, writing the majority opinion with the concurrence of Chief Justice Rehnquist and Associate Justices Kennedy, Thomas, Ginsberg, and Breyer, said, "Taking into account all the factors we have considered above—the decreased expectation

of privacy, the relative unobtrusiveness of the search, and the severity of the need met by the search—we conclude Vernonia's policy is reasonable and hence constitutional." Justice Ginsberg, in her concurring statement, pointed out that the Court reserved the question as to whether the school district could impose routine drug testing on all students.

*The medical profession should participate much more extensively in crafting informed, databased, balanced policies.*



Howard D. Slobodien, MD





*Individuality is the aim of political liberty. By leaving to the citizen as much freedom of action and of being, as comports with order and the rights of others, the institutions render him truly a free man. He is left to pursue his means of happiness in his own manner.*  
James Fenimore Cooper, *The American Democracy*, 1838

*America is not anything if it consists of each of us. It is something only if it consists of all of us.*  
Woodrow Wilson, in a speech on January 29, 1916

Justice O'Connor, joined by Justices Stevens and Souter in her dissenting opinion, wrote that suspicionless testing, because of the numbers involved, posed greater threats to liberty than did suspicion-based ones. She said in the past the Supreme Court had allowed exceptions to per se unreasonableness of suspicionless searches only where suspicion-based regimes would be ineffective, and that judges or government officials should not be the ones to decide which method of testing is better or worse. She felt that "the District's suspicionless policy of testing all student athletes sweeps too broadly, and too imprecisely, to be reasonable under the Fourth Amendment."

Eric Smith, in a copyrighted internet home page, published, "Fourth Amendment, December 15, 1791—June 26, 1995, R.I.P." He recommended that "Supreme Court Justices, congressmen, and other elected and appointed officials," who are "public figures and thus have a reduced expectation of privacy . . . should not mind admitting to mandatory drug testing," and he proposed this be done immediately.

Society has endorsed suspicionless testing of athletes for many years. It has included testing for both performance-enhancing and for mind- or mood-altering drugs. As reported in *JAMA*, on February 7, 1996, the International Olympic Committee prohibits stimulants, narcotics, anabolic agents, diuretics, peptides, and glycoprotein hormones such as erythropoietin, and has "varying restrictions on alcohol, corticosteroids, local anesthetics,

$\beta$ -blockers, and some  $\beta_2$ -agonists." Many professional sports have well-formulated drug-testing policies. Certainly, a substantial number of us, including Dr. Louria, support random drug testing of those in positions potentially hazardous to the public, e.g. pilots.

Unfortunately, many keen observers feel the climate today, including pop culture, is leading to increased drug use. There is no single good or right decision to be made regarding drug abuse and testing, but it is easy to make bad or wrong ones. Good or bad, right or wrong, ethical or unethical, moral or immoral or amoral—we shall pit philosophy against pragmatism; hence the (other) discussions regarding decriminalization or legalization and the concerns about Fourth Amendment rights. Although these rights are not merely abstruse philosophical ones, because they affect the quality of life, the conflict between individual and societal rights presents as a Hobson's choice and probably will last as long as our present system of government continues. The decisions can never satisfy all of us and are subject to continual change, so have we really "gutted" the Fourth Amendment?

The medical profession should participate much more extensively, as Dr. Louria suggests, "The medical profession should play a major role in crafting informed, databased, balanced policies. Medical educators can play a particularly important role." (As an aside, have the physicians, under managed care, lost some of their Fourth Amendment rights?)



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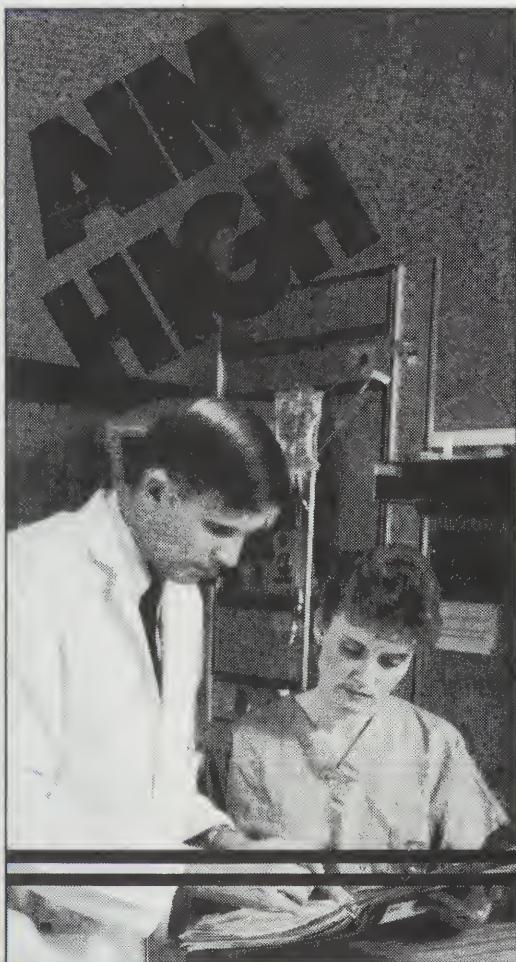
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## INTERVIEW WITH GEORGE R. LAUFENBERG

**George R. Laufenberg is the administrative manager of the New Jersey Carpenters Funds, four funds that total nearly \$600 million in revenues and provide health, pension, annuity, and vacation benefits to more than 12,000 union members, their families, and 3,000 retirees.**

**He serves as vice-president of Region 6 of the Jersey Coast Health Planning Council, co-chair of the Health Care Payers Coalition of New Jersey, founding member of the New Jersey Coalition for Healthcare Reform, and member of the Board of Trustees of Monmouth Medical Center. Mr. Laufenberg also serves as chair of the Board of Directors of the Alliance for Action.**

**Q.** Let's start with a "big picture" question. As someone who is involved with health care on many levels in this state, do you think we are moving in the right direction?

**A.** I think we've come far and are heading in a direction that will benefit the majority of people. I think we're going to become better educated consumers of health care, and in doing so, we're going to convince physicians to communicate better.

**Q.** Don't some people believe that health care and medical issues are simply too complicated for the average person?

**A.** It depends on how you define average. There is a segment of our society that will not be concerned about those issues because they are more involved in day-to-day issues of survival. However, I think the average person can see the economic differences involved in various procedures and can ask the right questions. In the past, people were intimidated by the



*George R. Laufenberg*

medical profession, but I think that is changing.

**Q.** Tell me something about the Health Care Payers Coalition, which is playing a key role in this educational process. How does it work? Why was it created?

**A.** About four or five years ago, a number of benefit managers and other interested players got together and decided that we needed better information about the cost and quality of health care. Some of the charges that we were seeing simply made no sense. At one hospital in Newark, for instance, the cost for a cardiac procedure might be \$90,000, while across the street at another hospital it was \$50,000.



## *The Health Care Reform Act of 1992, which deregulated hospital operations, has brought about greater competition and spurred a movement toward consolidation.*

We realized that public officials, for whatever reasons, often were prevented politically from being very forthright about this data, or did not have the ability to collect and disseminate it rapidly. What happened in health care last year doesn't really help us today, because things often change so quickly.

So, we decided that we should participate in the process by measuring outcomes and identifying these "bad actors" who were adding unnecessary costs to the system. We wanted to be fair about it, but we wanted to pay a reasonable rate for quality health care.

**Q.** But you're not only a data collection unit—you're a purchasing unit, too?

**A.** Yes, the purchasing cooperative is a nonprofit entity, an outgrowth of the Payers Coalition. It's a way in which self-insured, self-administered employers and Taft-Hartley trust funds can get together and negotiate favorably priced contracts with doctors, hospitals, testing

facilities, and other health organizations.

**Q.** Aren't we moving in the direction of greater consolidation on every level? You seem to be consolidating on the consumer end, but the same thing is happening on the provider end.

**A.** Absolutely. The state strategy under Governor Florio aimed at closing certain hospitals, but the public outcry was unbelievable. Now, it is going to be very difficult for certain hospitals to survive unless they start merging, consolidating services, or downsizing. The perfect hospital today would be a 200- to 300-bed facility. The larger institutions have too many empty beds.

The Health Care Reform Act of 1992, which deregulated hospital operations, has brought about greater competition and spurred a movement toward consolidation. Competition is fine, but we've got to keep the playing field level, and that's clearly not the case for the larger urban hospitals, which

have a large population of poor, uninsured patients and which are at a strategic and economic disadvantage.

**Q.** Where do you see managed care fitting into all this? Are many of your members participating in managed care?

**A.** We don't penalize our members if they choose to participate in a managed care plan. We've structured our health programs to try to get physicians to participate as managed care providers. We tell our members that if they go to participating physicians, we will waive deductibles and co-pays. If you really want to control health care costs, you've got to modify physician behavior—the tests that are performed, where they are performed, what hospitals will admit you, and the specialists you see. If we are going to solve the cost problem, we have to bring physicians to the table.

The Payers Coalition recently signed an agreement with the Physician Healthcare Plan of New Jersey. They've

## *The improvement rate of c-sections demonstrates what can happen when we ask physicians, "If the national average is X for a procedure, why are your rates twice that figure?"*

agreed to specific fees for services and will utilize testing facilities with which we have agreements. This will save money for our members. In all of our negotiations, however, we demand that our members retain complete autonomy and freedom of choice.

**Q.** Doesn't it sound like physician behavior is being modified today through the marketplace and through the emergence of HMOs and purchasing groups like your own?

**A.** Yes, it is. In fact, I think that physicians need a union today more than many other professions. They are all over the lot. Many are following what the hospitals are doing and signing contracts with anybody who will take them. But I think physicians could never form a union because if you looked at their psychological profiles, you'd find a lot of "independent thinkers."

**Q.** Do you see ways in the future to come up with measures of quality care, such as patient satisfaction surveys?

**A.** We have to be very careful about surveying quality care matters, or trying to correlate patient satisfaction with quality care. For instance, if you were to tell me a patient is satisfied that he only waited ten minutes to be seen by a



physician, rather than an hour, or that the doctor spent an extra five minutes with him, I'm not convinced that his satisfaction addresses quality care factors. If you are waiting for a diagnosis for cancer or gallbladder or a heart problem, I don't think a friendly receptionist is a significant factor.

**Q.** Earlier on in this conversation, you said that you saw a trend toward better-

educated physicians. What do you mean by this?

**A.** I read a couple of studies that suggested most physicians tend to practice what they are taught in medical school. This is very relevant for certain procedures, such as cesarean sections. If you remember, not too long ago the state released the c-section rates for hospitals, and the figures weren't bad, somewhere about the national average. Only a few years before that, however, we saw rates among our own members that were substantially higher.

This improvement demonstrates what can happen when we can sit down with a group of physicians and say, "If the national average is X for a certain procedure, why are your rates twice that figure?" Is it something in the demographics of New Jersey? Is it personal preference? Is it an economic issue?

If you get rational people together in a room, you can usually come up with rational solutions.





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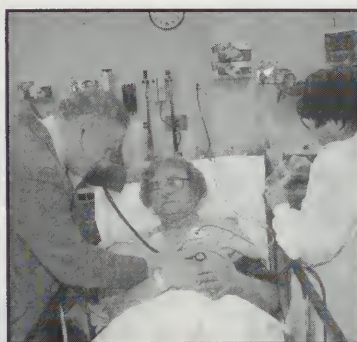
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*Earl V. Wells*

## Financing care for the uninsured: The dilemma vexes New Jersey hospitals and payers

New Jersey's diverse constituencies and special interest groups don't usually agree on a public policy issue. However, almost everyone in the public policy arena agrees that hospitals should treat people who show up in emergency departments with problems requiring medical attention. For over a decade, Garden State policymakers, payers, and providers have faced the dilemma of excess demand on hospitals that treat the uninsured. This demand has risen due to increasing health care costs, development of costly technology, state deregulation of hospital payments, and employers' reluctance to insure workers and their families coupled with a mobile workforce holding part-time and seasonal jobs. The fiscal solvency of inner-city hospitals is threatened yet the problem continues to elude resolution.

Hospitals in the Garden State have a tradition of providing "charity" care to the uninsured, but the magnitude of the problem in New Jersey is "not even close to other states" according to New Jersey Hospital Association President Gary S. Carter. Through a succession of largely hidden taxes, the cost of uncompensated care has been shifted to



©Conrad Gloos

payers, most notably employers and labor unions.

And therein lies the rub: How do the hospitals in New Jersey continue to provide charity care for Garden State residents when reimbursement for treating the uninsured is becoming increasingly difficult to find?

The funding mechanism implemented in 1992 to reimburse hospitals for uncompensated care called for a "tax" on the state's unemployment trust

fund. This was a central tenet of the landmark Health Care Reform Act signed into law by Governor Jim Florio. When this component of the Act expired on December 31, 1995, legislators tried to extend the provision for another three years. Business and labor groups vehemently opposed the extension.

Advanced late last year as a funding source supported by Governor Christie Whitman, the health care community and—according to an Eagleton Institute Poll—approximately 80 percent of the general public, was a tax on tobacco products. Republicans fearful of being associated with any tax increase, Democrats eager to see a funding shortfall resulting from GOP control of state government, an Assembly that lacked trust in the Senate, a Senate that lacked trust in the governor, and a powerful, well-heeled tobacco lobby combined to kill the tobacco tax, while business and labor sat on the sidelines.

As posturing over finding a permanent funding mechanism by legislators and various interest groups continues, the number of uninsured in New Jersey grows unabated. According to the New Jersey state Department





*Sister Jane Frances Brady,  
president, St. Joseph's Medical Center*

of Health (DOH), more than a million Garden State residents do not have health benefits, up from more than 800,000 four years ago. Despite these figures, the system, as a result of deregulation, is beginning to shake out. "Health benefits inflation is falling, making benefits plans more affordable, and the result is a growing number of businesses offering health insurance to their workers," claims Dawn Perotta, assistant vice-president of the powerful New Jersey Business & Industry Association (NJBIA). Perotta is correct, to an extent, as costs have slowed due to the ability of managed care companies to negotiate discounted rates with hospitals, physicians, and other providers.

A spin-off of the New Jersey Hospital Association, the urban-based New Jersey Hospital Alliance has claimed, in a statewide advertising campaign, that two-thirds of the uninsured are working men and women. "The NJBIA survey is not a true reflection of the current state of the working uninsured," said Sister Jane Frances Brady, president of St. Joseph's Medical Center in Paterson and the lead spokesperson for the Alliance. Facilities like St. Joseph's that treat a disproportionate number of the uninsured see themselves at a competitive disadvantage with other typically suburban hospitals in the deregulated sys-

tem that Carter estimates will result in the closing of at least 40 hospitals by the year 2000.

Reimbursing hospitals for uncompensated care is not the only possible approach. One key feature of the 1992 reforms was creation of a new program, later named Health Access New Jersey, to subsidize insurance premiums for individuals and families that find insurance unaffordable but do not qualify for Medicaid. The amount of the subsidies is tied to income, under a sliding scale.

But, despite an initial flurry of interest, enrollment in Access has barely dented the problem. The subsidies proved most popular with people who were between jobs. "Access has never really got off the ground," says William E. Ryan, MD, a past-president of MSNJ and a reform advocate. Dr. Ryan believes that managed care companies should help resolve the charity care dilemma by contributing ideas as well as a share of their cash reserves.

The subsidized insurance approach is especially popular with physicians. Unlike New Jersey hospitals, which until this year received large and prompt payments for treating the uninsured, the state's cadre of privately practicing physicians receives no compensation for charity care. In the late 1980s, DOH estimated the annual physician contribution at \$500



*Gary S. Carter, president,  
New Jersey Hospital Association*

million. It can only have grown since then, while doctors' ability to shift costs has shrunk remarkably.

To reduce demand for costly hospital emergency department care, the state Medicaid program is moving down the path toward managed care. Medicaid officials hope that better quality of care and increased access to services also will occur under managed care, as Medicaid recipients gain a primary care physician and a system of referral to specialists. This bright vision resembles early hopes for the Access program and may prove just as fleeting. Only 3 percent of New Jersey's Medicaid expenditures go for physician services. Without additional funding, medical care will not meet the ideal of more and better. And, under the current federal and state austerity scenarios, funding for Medicaid is going anywhere but up.

In this sad state of affairs, Governor Whitman and DOH Commissioner Len Fishman have unfurled a scheme, called Children First, to cover medical care for children of uninsured families by revamping the Access program. The plan relies on success in the Legislature in finding a funding source to bail out hospitals, with some of the income stream left over for kids. This may happen in the short term, but don't look to politically powerful hospitals in future years to foreclose on the idea of hospitals first.

How did we get to this place? Does the past hold the key to the future?

Before 1992, hospitals could afford to treat the uninsured through a surcharge that appeared on every patient's hospital bill as part of the diagnostic related group (DRG) system. Under DRGs, used to regulate payment to New Jersey's hospitals from 1978 until 1992, money collected from the surcharge was pooled into a fund and distributed to hospitals according to the amount of uncompensated care they provided to the uninsured. "The 1978 DRG law called for an all-payer rate system because inner-city hospitals were beginning to experience increasing revenue losses and needed help," said Pamela Dickson, former assistant commissioner of health and now director of health care reform in Commissioner Fishman's department. "It became clear by 1989 that the system was breaking down.

Appeals to the surcharge by patients and hospitals were backing up and swamping the system," Dickson continued. Adds David Knowlton, former deputy commissioner of health: "DRG was a fair system, but charity care unraveled it."

Charity care in fact was unraveled by the Health Care Reform Act of 1992 whose impetus was a lawsuit against the DRG system. In *United Wire Water Metal and Machine versus Morristown Memorial Hospital*, the plaintiff union benefits fund charged that self-insured health funds used by corporations and labor unions could not be regulated by the state because of federal pre-emption in the Employee Retirement Insurance System Act. When federal district court Judge Wolin shocked the state by agreeing with the union, Florio and the Legislature stepped in with the 1992 reforms. Not surprisingly, Sid Meyer, who represented United Wire and now is senior vice-president of Multiplan in New York City, concedes that, while the reforms have worked to the betterment of everyone in the system, charity care funding remains a problem.

Sister Jane puts the issue bluntly: "The Act that deregulated the system changed the entire environment by putting hospitals in a competitive mode, and we are struggling to get on our feet."

No one expects that siphoning money from the unemployment trust fund will be the long-term solution, simply because the business and labor lobbies have concluded that enough is enough. For that matter, political grandstanding has all but eliminated adoption of broad-based funding measures that directly affect the pocketbooks of Garden State residents, such as a sales or income tax hike.

Laced through the charity care dilemma is a web of tensions: between federal reformers and state apologists, between hospital executives and advocates for the poor, between social engineers and politicians, between health care providers and payers. What is needed is a weaver, a great reconciler. We don't have one.

Earl V. Wells is a freelance writer and a public relations executive. New Jersey *MEDICINE's* editorial staff contributed to this story.

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## MODEL OF COMPREHENSIVE DIAGNOSIS AND CARE FOR BREAST CANCER PATIENTS

*David A. August, MD  
Robert S. DiPaola, MD  
Thomas Kearney, MD  
William Hait, MD, PhD*

**The authors are affiliated with The Cancer Institute of New Jersey, New Brunswick. Drs. David August and Thomas Kearney also are affiliated with the Department of Surgery, Division of Surgical Oncology, and Drs. Robert DiPaola and William Hait are affiliated with the Department of Medicine, Division of Medical Oncology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick.**

Care of patients with cancer of the breast is an interdisciplinary endeavor performed by specialists. The patient participates through breast self-examination and articulation of personal preferences.<sup>1</sup> Primary care clinicians and obstetrician/gynecologists often oversee breast cancer screening.<sup>2</sup> Radiologists supervise acquisition and interpretation of breast imaging studies.<sup>3</sup> Tissue diagnosis now involves the use of techniques such as fine-needle aspiration, stereotactic biopsy,

hormone receptor assay, and molecular prognostication. Application of these methods requires the coordinated efforts of primary care practitioners, surgeons, radiologists, pathologists, cytologists, and molecular biologists.<sup>4</sup>

Treatment planning also has changed. No longer can a surgeon make a diagnosis and perform surgery before the patient even knows that she has cancer. Breast conserving treatment is an excellent option for most women with breast cancer. Proper consideration of this option requires preoperative consultation with a surgeon and a radiation oncologist.<sup>5</sup> Medical oncology, embryonic 25 years ago, currently plays a crucial role early in the treatment planning process. Prior to initiation of definitive treatment, the medical oncologist must have an opportunity to suggest appropriate neoadjuvant approaches and to advocate use of specific staging studies, e.g. axillary lymph node dissection, if initial therapy is to be optimal. For those women requiring or choosing mastectomy, breast reconstruction must be considered prior to definitive surgery if the patient is to be

offered a full range of restorative options.<sup>6</sup>

Long-term care of patients with breast cancer also is improved when an interdisciplinary approach is used. Timely, cost-effective, and appropriate treatment of complications and recurrent or persistent disease is encouraged by interdisciplinary followup. It also facilitates participation by allied health professionals to assure that patients' psychosocial needs are identified and accommodated. Interdisciplinary care also can facilitate patient participation in clinical trials requiring prospective data collection and adherence to treatment protocols.

All of these issues speak to the need for an interdisciplinary, comprehensive approach to the treatment of breast cancer patients. In meeting these objectives, however, administration of high-quality, compassionate, and supportive care must be paramount. Patients need to establish a personal relationship with a treating physician. This article discusses the establishment of a comprehensive program for the evaluation and care of women with breast cancer and the benefits



*For women requiring or choosing mastectomy, breast reconstruction must be considered prior to definitive surgery if the patient is to be offered a full range of restorative options.*

that may be realized from such an approach.

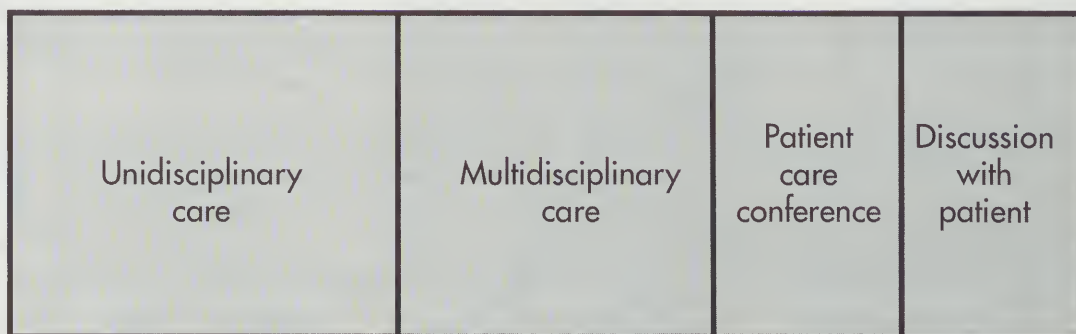
Traditionally, breast cancer care has been offered using a unidisciplinary model in which patients are referred from physician to physician. In this model, although the physicians communicate with each other, decisions generally are made by individuals or in binary consultations.

An alternative model of breast cancer care has been described.<sup>7-10</sup> We currently are implementing such a system at The Cancer Institute of New Jersey (CINJ). The goals of this system are facilitation of: optimal medical care; patient con-

venience; clinical efficiency; patient access to supportive services from social workers, other allied health professionals, and peer counselors; and clinical and outcomes research.

Patients come to the New Jersey Comprehensive Breast Care Center (NJCBC) by physician or self-referral. When an initial visit is scheduled, a specially trained receptionist instructs the patient to bring mammograms, pathology slides, and other appropriate information. This makes all relevant information available to clinicians at the time of the initial evaluation. New patients presenting to NJCBC initially

are assessed by a nurse clinician. A major responsibility of the nurse clinician is triage. The patient and the nurse decide cooperatively which physicians, support services, and research protocols are relevant. According to the triage plan, the patient remains in a single examination room and is seen by a surgical oncologist, a medical oncologist, a radiation oncologist, and a social worker, as appropriate. This eliminates the burden to patients of scheduling multiple physician visits. While new patients are being seen, their outside pathology slides are reviewed by a pathologist and their



**8 A.M.**

**1 P.M.**

**3 P.M.**

**4 P.M.**

**5 P.M.**

**Figure 1.** Organization of NJCBC schedule. Patients are seen on Thursdays. The morning is dedicated to traditional, unidisciplinary patient visits. Multidisciplinary care is concentrated between 1 P.M. and 3 P.M. During this period, each patient remains in an examination room and is seen by nurses, social workers, and physicians from different disciplines as appropriate. Patient cases are presented at the one-hour patient care conference where pathology slides and diagnostic images are available for review. After the patient care conference, the physician primarily responsible for the patient's care returns to the clinic to present the recommendations to the patient and to answer questions.

*Prior to definitive treatment, the medical oncologist must have an opportunity to suggest appropriate neoadjuvant approaches and to advocate use of specific staging studies.*

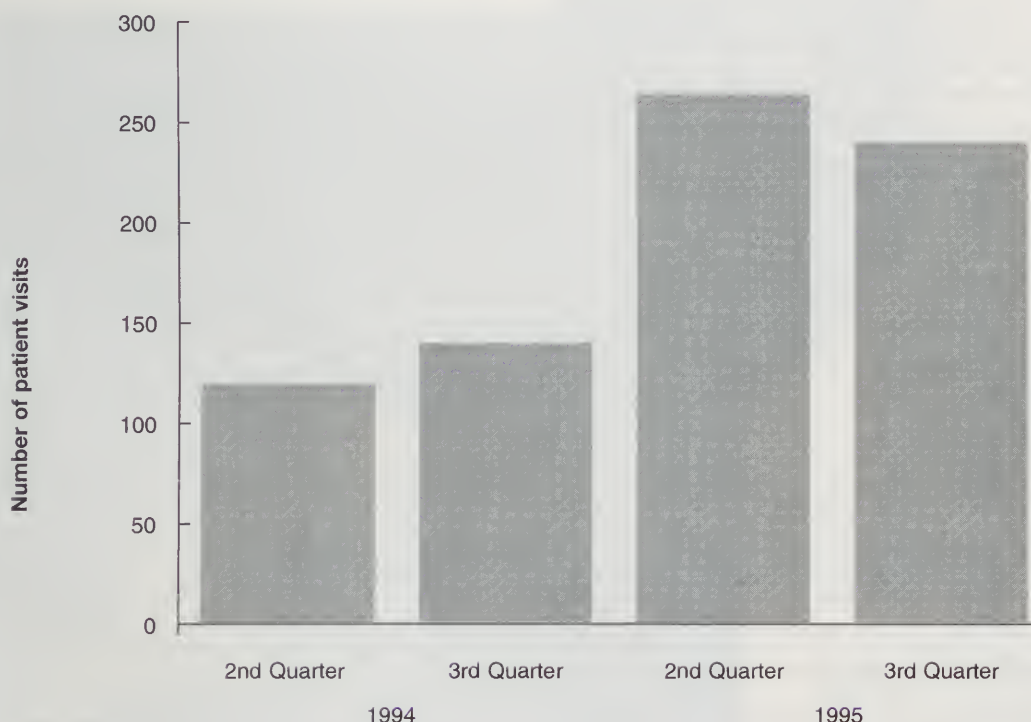
imaging studies are reviewed by a radiologist. Simple procedures such as fine-needle aspiration biopsies may be performed with readings available for review at the patient care conference.

Return visit patients also are seen at NJCBCC. These are patients currently under evaluation, receiving treatment, or engaged in followup programs who have previously been seen at NJCBCC and require additional interdisciplinary evaluation.

Patients at NJCBCC are presented and discussed at a one-hour patient care conference immediately following the two-hour multidisciplinary clinical session (Figure 1). The conference is attended by medical, surgical, and radiation oncologists; plastic surgeons; pathologists; radiologists; nurses; social workers; and members of the CINJ Clinical Research Office. Radiology, pathology, and other clinical data are reviewed; evaluation and treatment recommendations are for-

mulated; eligibility for clinical trials is assessed; tissue procurement for studies is planned; and followup problems and data are discussed. Minutes of each patient care conference are recorded, and a data form is completed. Data are entered into a computerized database. The database is periodically updated with treatment and followup information obtained by the CINJ Clinical Research Office.

After the conference, recommendations are presented by



**Figure 2.** Patient care activity at NJCBCC. The multidisciplinary session began operation in March 1995. The second quarter of each year begins on April 1.



*The goals of the system are facilitation of optimal medical care, patient convenience, clinical efficiency, patient access to support services, and clinical and outcomes research.*

the treating clinicians to patients, and subsequent studies and procedures are scheduled and coordinated. Patients also are given the opportunity to be evaluated by additional specialists whose input or involvement is felt to be important.

Patients at NJCBCC are charged a single, discounted, bundled fee, which is collected by CINJ. Physicians and allied health professionals participating at NJCBCC are not compensated for the time they spend at NJCBCC; they do, however, charge a professional fee for patient services provided beyond the walls of CINJ, e.g. surgeon's fee for breast biopsy, pathologist's fee for reading of slides, medical oncologist's fee for administering chemotherapy.

NJCBCC opened in August 1994; in March 1995 the multidisciplinary clinical sessions and the case conferences were established. Patient care activity at NJCBCC has grown rapidly (Figure 2). As of October 1, 1995, 571 women have been seen at NJCBCC since the establishment of the multidisciplinary session. Of these patients, 69 women were making initial visits and 502 women were making return visits. In 524 patients, a diagnosis

of breast cancer was established or confirmed. Of the 69 new patients, 35 women received multidisciplinary evaluations, i.e. were seen by a representative of more than one medical specialty.

More than 80 percent of patients seen with primary operable breast cancer for whom breast conserving therapy was an option actually chose and achieved breast conservation. Of the 19 patients who came to NJCBCC for sec-

ond opinions, 5 women (26 percent) had their cancer either up staged or down staged, or received treatment recommendations that differed significantly from the primary opinion (Table 1). NJCBCC also has successfully enrolled patients in clinical trials (Figure 3). Of the 35 patients who received multidisciplinary evaluations, 20 women (57 percent) were offered participation in a clinical trial. At the current time, 8 of these patients (40 percent) have opted to enroll in a clinical

**Table 1.** Findings during patient evaluation at NJCBCC resulting in changes in tumor staging and treatment recommendations.

Patient Finding	Recommendation
1 History revealed presence of connective tissue disorder	Radiation therapy relatively contraindicated; mastectomy recommended
2 Physical findings not consistent with locally advanced cancer	Patient downstaged; primary breast conserving surgery recommended
3 Bone scan directed biopsy demonstrated presence of metastatic disease	Stage IV breast cancer; primary chemotherapy recommended
4 Physical examination and fine-needle aspirate revealed supraclavicular node metastasis	Stage IV breast cancer; primary chemotherapy recommended
5 Physical examination and fine-needle aspirate revealed supraclavicular node metastasis	Stage IV breast cancer; primary chemotherapy recommended

*More than 80 percent of patients seen with primary operable breast cancer for whom breast conserving therapy was an option actually chose and achieved breast conservation.*

cal and/or translational research trial.

The University of Michigan Breast Care Center (UMBCC) has presented its experience with multidisciplinary breast care.<sup>7-10</sup> This experience in a mature breast center program supports and expands upon the CINJ experience. UMBCC accommodates more than 3,000 patient visits annually, including over 1,200 visits by cancer patients.<sup>10</sup> Roughly 30 percent of the cancer visits are multidisciplinary. The UMBCC experience suggests there are clinical, financial, and academic benefits of comprehensive breast care and that the level of patient satisfaction is high.<sup>7,10,11</sup>

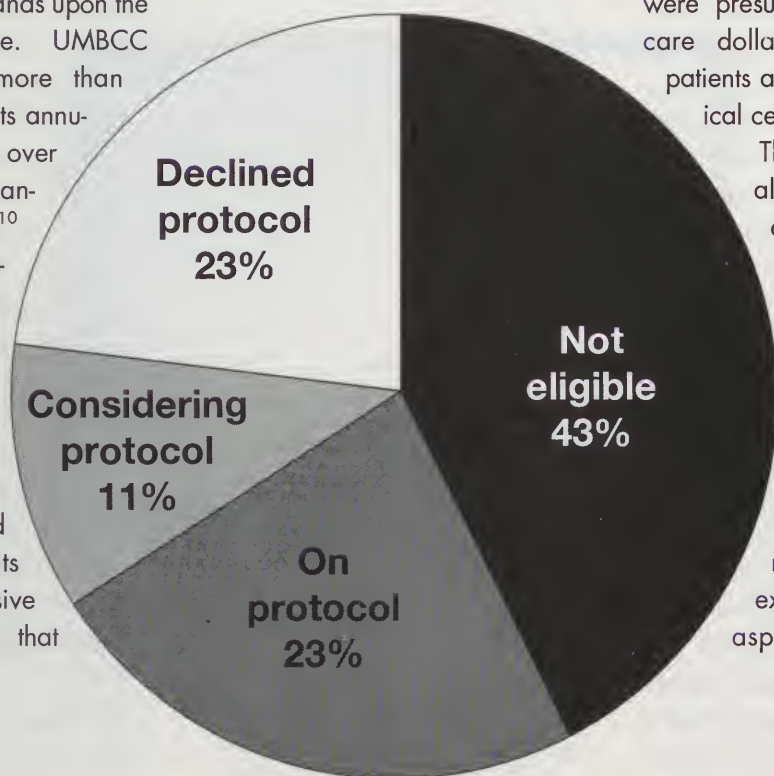
Over a six-year period, development of the UMBCC led to an approximate sixfold increase in the number of patients with breast cancer cared for at the University of Michigan.<sup>10</sup> At the medical center, breast conservation

now is achieved in more than 50 percent of women treated for invasive carcinoma. In women undergoing mastectomy, breast reconstruction is commonly offered and used.<sup>6</sup> Standards for completeness of pathologic information and for

Financially, UMBCC generated \$2.3 million of revenue directly related to breast care annually from 1989 to 1991; an additional \$2.7 million annually was generated for services not directly related to breast care, some of which were presumably new health care dollars attributable to patients attracted to the medical center by UMBCC.<sup>11</sup>

The Michigan group also has reported data concerning patient evaluation of multidisciplinary breast care.<sup>7</sup> Fifty-nine percent of the 1,023 consecutive patients polled did respond. Questions exploring multiple aspects of patients' experience at UMBCC revealed almost uniformly favorable impressions, averaging between 4.27 and 4.52

on a 1 (least favorable) to 5 (most favorable) Likert scale. It is noteworthy that both patients with cancer diagnoses and patients with benign breast disease expressed favorable



**Figure 3.** Patient enrollment in clinical trials through NJCBCC. Thirty-five patients were evaluated in the multidisciplinary patient care conference to assess their eligibility for protocol participation.

use of adjuvant systemic therapy in UMBCC breast cancer patients are met almost uniformly. All of these facts are markers of the clinical quality and success of UMBCC.



## *The UMBCC experience suggests that there are clinical, financial, and academic benefits of comprehensive breast care and that the level of patient satisfaction is high.*

impressions, but the responses of cancer patients were consistently more positive. In a multivariate analysis, four factors best correlated with a favorable patient experience at UMBCC: the UMBCC staff level of concern about patients emotional and physical welfare; the convenience of one-stop-shopping; thoroughness of medical evaluations; and length of time spent in the UMBCC on the day of the visit (negative correlation).

It is instructive to analyze the NJCBCC and the UMBCC experiences in light of the objectives for which they were established (Table 2).

### **Optimal medical care.**

According to patients, provision of optimal care is a major benefit of the multidisciplinary model of breast care. Patients feel that simultaneous consultation with multiple experts is evidence of quality care. At NJCBCC, interactive patient evaluation and treatment planning are crucial elements of multidisciplinary care. For all viewpoints to compete equally, they must be expressed early in

the evaluation process, before plans have become set in clinicians' and patients' minds. Furthermore, interactive evaluation and treatment planning facilitate the process of ongoing peer review and continuing peer education. In this

**Table 2.** Objectives for development of a multidisciplinary breast care system.

#### Facilitation of:

- Optimal medical care
- Patient convenience
- Clinical efficiency
- Patient access to supportive services
- Clinical outcomes, and basic research

model of care, clinicians continually explain and justify decision making to expert colleagues.

At NJCBCC and UMBCC, care is taken to assure that a single physician is available for explaining recommendations and making treatment decisions with each patient. Patients should not feel that they are being treated by committee. The UMBCC data confirm the importance of patients' perceptions of the

importance of staff concern about their emotional and physical welfare. Whether the medical outcomes of women with breast cancer actually are improved by care in an interdisciplinary setting remains to be determined. Data

at both CINJ and the University of Michigan concerning diagnostic and therapeutic recommendations, frequency of breast conservation, frequency of breast reconstruction, and appropriateness of pathological analysis and adjuvant therapy decisions all suggest that the

patients are receiving excellent care.

### **Patient convenience.**

Convenience ("one-stop-shopping") was the factor that patients most consistently and strongly identified as a benefit of UMBCC. This is despite patients' displeasure with the length of the visit (often exceeding three hours to accommodate multidisciplinary evaluations). Patients felt that the long residence time in the clinic was far outweighed

*Care is taken to assure that a single physician is available for explaining recommendations and making treatment decisions; a patient should not feel she is being treated by committee.*

by the benefits of a multidisciplinary evaluation. Given the travel and waiting time that patients avoided by not having to visit multiple physicians in separate offices at separate times, it is clear that being at UMBCC for three or more hours was actually an efficient and effective way to spend time. Our experience at CINJ has been similar. Most patients choose to wait at NJCBCC until the case conference is completed, so that they can meet with additional specialists as needed and have a summary discussion with their primary physician. Patients want to complete their evaluation in one visit, in part for convenience but also to limit the period of uncertainty and anxiety that occurs between the time of initial diagnosis and the initiation of definitive therapy.

**Clinical efficiency.** No hard data exist concerning the effect of the multidisciplinary model on clinicians. Almost uniformly, physicians, nurses, and social workers enjoy this practice model. Word of mouth attests to its efficiency. Because all relevant data, including pathology slides, mammograms and other diagnostic imaging studies, medical consultations,

and psychosocial evaluations are discussed at the patient care conference, there is no need to subsequently track down this information. Patients' needs are comprehensively discussed and addressed in a single hour.

**Patient access to supportive services.** Patient evaluation by a social worker experienced in dealing with breast cancer patients is an integral element of the multidisciplinary care model. All breast cancer patients at the University of Michigan and at CINJ are seen by a social worker. Participation of a full-time social worker in both programs has stimulated the development of a variety of educational and supportive programs for patients, their families, and the broader community. Programs have been created to assist younger patients, older patients, patients with families, patients under active treatment, patients in long-term followup, patients with recurrent disease, patients' spouses, patients' children, and patients considering breast reconstruction.

**Facilitation of clinical and outcomes research.** The multidisciplinary model of

comprehensive breast care is research friendly. UMBCC plays an important role in the support of academic endeavors, including competition for grant support and peer-reviewed publication.<sup>9</sup> Experience at NJCBCC has been similar. The patient care conference functions as a clearinghouse to identify protocol eligible patients, facilitate clinician recruitment of study participants, and assess the availability of tissue specimens for use in basic and translational investigations. More than 20 percent of patients evaluated at the NJCBCC multidisciplinary conference are ultimately enrolled in clinical trials. The patient care conference is a unique forum for basic researchers to work with clinicians and clinical issues. Basic scientists regularly attend the weekly conference. It also permits laboratory researchers to solicit input and support from clinicians. The working relationships fostered in this environment stimulate translational research by bringing clinical and basic scientists together.

**Conclusion.** Optimal care of women with breast cancer requires evaluation and treatment by specialists in multiple disciplines. These experts can work together effectively only if



## *The multidisciplinary model of comprehensive breast care is research friendly. UMBCC and NJCBB play important roles in the support of academic endeavors.*

their participation in an individual patient's care is prospective, ongoing, and interactive. Centers that specialize in breast cancer can create the necessary clinical environment by establishing breast care units that emphasize comprehensive, interdisciplinary diagnosis, and treatment planning. At CINJ, we have created a physical space that can accommodate the needs of multiple clinicians simultaneously and we have oriented participants to a new style of practice. NJCBCC supports a nurse practitioner, a social worker, and a clinical database. The success of NJCBCC at CINJ and the accomplishments of UMBCC attest to the importance and vitality of a comprehensive, interdisciplinary approach to the care of women with breast cancer.

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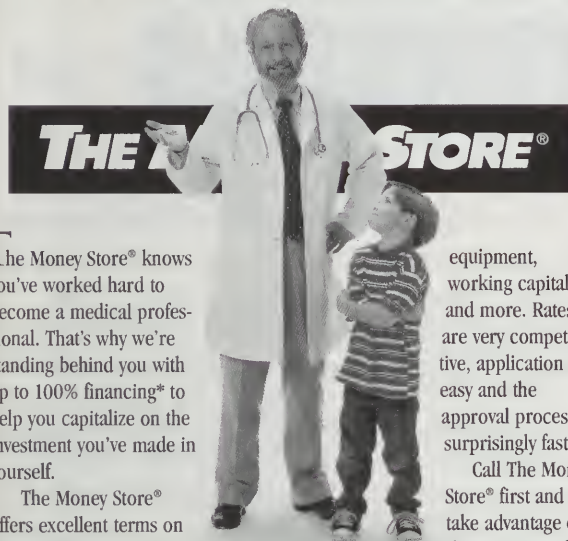
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ISF031

## METASTASES FROM METASTASIS: A CAREFUL EXAMINATION

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It has been hypothesized that metastases do not occur by random dissemination of cancer cells from a primary tumor but rather from a specific cascade of spread.<sup>1,2</sup> According to the cascade theory, the primary tumor metastasizes to key sites and it is the metastatic tumor at these secondary sites that disseminates tumor throughout the body.<sup>3</sup>

The concept of metastases occurring from metastasis is not a new one.<sup>4</sup> Experimentally, it has been shown that pulmonary metastases shed viable tumor cells and blood from these animals will produce metastatic tumors when injected into normal syngeneic recipients.<sup>5,6</sup> Sugarbaker demonstrated that host tumor-specific immunity develops against the metastatic tumor and while not preventing the shedding of viable cancer cells, it will prevent the growth of tertiary deposits.<sup>7</sup> Ketcham's work suggested tumors are heterogeneous and metastatic cancer cells can escape immune surveillance producing further dissemination of tumor. Ketcham

joined two syngeneic animals in order to develop a common circulation allowing passive transfer of immunity. Following amputation of the primary tumor, animals were joined by parabiosis. Both animals were found to have pulmonary metastatic tumors suggesting metastases from metastasis do occur despite tumor specific immunity.<sup>8</sup>

Clinical studies have been limited to autopsy reviews. Viadana and Bross examined metastatic patterns in humans by statistical analysis of autopsy data.<sup>1</sup> This review demonstrated that tumors have specific organs to which they metastasize. Other solid organs develop metastases only after the key sites have been seeded with tumor. These data also suggest metastases were occurring from metastasis.

Autopsy data are limited because they represent a fixed point in time and do not lend themselves to examination of latent tumor growth. Also, primary tumors are heterogeneous and may shed tumors that vary in their sites of metastases and growth rates. The ideal clinical example of metastases from metastasis is a patient with a metastatic tumor that has metastasized to regional lymph nodes, which are spe-

cific for that organ. This paper reports a patient who meets these criteria and reviews the literature on metastases from metastasis.

**Methods.** A 48-year-old black male presented to the VA Medical Center in East Orange, with the chief complaint of gross hemoptysis. The patient coughed 200 cc of blood prior to admission. Chest x-ray and computed tomography (CT) scan demonstrated a large, fluid-filled cavity in the right upper lobe without evidence of adenopathy or tumor. Endoscopic examination was negative except for positive *Aspergillus* culture. A right upper lobectomy was performed. The right upper lobe contained 750 cc of clotted blood. The histology demonstrated an undifferentiated squamous cell carcinoma lining the cavity of the right upper lobe without hilar or mediastinal lymph node involvement. The hospital course was unremarkable and the patient was discharged ten days later.

The patient was re-admitted the following month with complaints of abdominal pain and diarrhea. Sigmoidoscopy showed pseudomembranes and *Clostridium difficile* toxin was present. The patient was treated with vancomycin and



*This case demonstrates that viable tumor cells shed from metastatic tumors can escape the host immunity and continue to proliferate.*

had a protracted course with persistent fever, abdominal pain, and an elevated white blood cell count. CT of the abdomen was performed and was normal. He developed gastrointestinal bleeding requiring one to two units of blood a day that lasted for several days. Colonoscopy was normal but an esophagogastroduodenoscopy demonstrated several tumors in the second portion of the duodenum that were bleeding. An exploratory laparotomy was performed 12 days after admission and the patient was found to have multiple

tumors involving the entire small bowel from the second portion of the duodenum to the terminal ileum. There were no sites of tumor involvement other than the small bowel and its mesenteric lymph nodes. A small perforation was found in the distal jejunum and a small bowel resection was done with an end-to-end anastomosis. The 30 cm segment of small bowel removed contained approximately 25 intraluminal tumors each measuring 1 to 2 cm. The

histology was reported as undifferentiated carcinoma in both the small bowel tumor and involved mesenteric lymph nodes. On further review of the histology, this was reported as undifferentiated carcinoma consistent with the patient's lung primary suggesting tumor metastasizing from the lung to the small bowel, then from the



small bowel to mesenteric lymph nodes.

**Discussion.** Although the literature does suggest metastatic tumors can produce further dissemination of cancer cells, reports are sparse and the data are inconclusive. Sugarbaker's study suggested metastases from metastasis do not occur.<sup>7</sup> The experiment used a 3-methylcholanthrene(MC)-induced sarcoma. This tumor metastasizes early and exclusively to lung tissue. Tumor cells

were injected into thighs of animals and lung tissue was transplanted subcutaneously either before or after amputation of the primary tumor. Metastatic tumors developed in the transplanted lung tissue only in the animals receiving the transplant prior to the amputation. None of the animals receiving the lung transplants after amputa-

tion developed metastases despite the demonstration of viable tumor cells in left heart blood. The data suggest metastatic tumors shed viable tumor cells but are unable to grow secondary to tumor specific immunity.

Hoover and Ketcham's study using a technique

of parabiosis demonstrated metastases from metastasis despite tumor immunity.<sup>8</sup> Parabiosis was performed by joining two syngeneic animals' peritoneal cavities. Parabiosis produces a common circulation allowing the passive transfer of cells between animals. Animals were intramuscularly injected with either MC sarcoma, Lewis T241 sarcoma, or a mouse mammary adenocarcinoma. Following amputation of the primary tumor, animals were

*The ideal clinical example of metastases from metastasis is a patient with a metastatic tumor that has metastasized to regional lymph nodes, which are specific to that organ.*

joined by parabiosis. Both the guest and host animals were found to have pulmonary metastases. Tumor specific immunity was demonstrated when animals were challenged with a second intramuscular injection of tumor cells and no growth occurred in either the host or guest animals. Both Sugarbaker's and Ketcham's studies were excellent experiments with contradictory conclusions. Significant questions remain to be answered. Does the metastatic tumor need to reach a critical size before a subset of tumor cells, resistant to host immunity, can metastasize? Does tumor immunity fail with progression of tumor growth "immune paralysis" allowing metastases from metastasis to occur? Do metastatic tumor cells shed viable tumor cells that are dormant until the host is stressed? Does parabiosis allow sufficient transfer of host immunity to inhibit blood-borne metastases?

Clinical evaluation of metastases from metastasis has been limited to autopsy reviews.<sup>1,3</sup> Bross examined the metastatic cascade hypothesis by analyzing the metastatic patterns of patients who died of disseminated cancer.<sup>1,3</sup> Bross observed generalized disease to be rare unless metastases were present at certain key sites. As the number of patients with metastases to the key sites increased, pre-

dominately the lung and liver, the number of metastases to the central nervous system and endocrine glands also increased. When the liver and lungs were absent from metastases, only rarely would endocrine or central nervous system metastases be the same whether or not lung metastases were present. This study provided supporting evidence for the cascade theory, however, the data can be criticized since autopsy reviews are a static system and cannot evaluate tumor latency or tumor heterogeneity. Metastatic tumor cells have been demonstrated to lie dormant and are able to resume growth when the host is stressed.<sup>9,10</sup> Tumor heterogeneity is another important factor that should be analyzed when evaluating the data. Primary tumors are populated by a subpopulation of cells with differing metastatic potential.<sup>11-13</sup> Therefore, as the primary tumor grows, a different subpopulation of cells may predominate with a metastatic pattern that differs from the original tumor.

Our patient presented several interesting features. Most importantly, the patient demonstrated a clear example of metastases from metastasis. The patient presented hemoptysis; radiologic examination showed a large cavitory lesion to the right upper lobe. At the operation, the cavity was found to

contain 700 cc of blood and was lined by undifferentiated carcinoma. Four weeks later, the patient presented with an acute abdomen. At exploration, the small bowel and the mesenteric lymph nodes contained multiple tumors starting in the second portion of the duodenum and extending to the distal ileum. The lung must have been the primary tumor rather than the small bowel since virtually the entire small bowel was covered with multiple metastatic tumor nodules. Since the mesenteric lymph nodes only drain the small bowel the metastatic spread must have been from the lung primary, to the small bowel, and then to the mesenteric lymph nodes.

The small bowel and lung provide a unique opportunity to study metastases from metastasis since their lymphatic drainage is specific for those organs. DeCastro's review of small bowel metastases noted 10 to 26 patients with small bowel metastasis to contain nodal involvement in the small bowel mesentery.<sup>14</sup> Metastatic tumors to the lungs have been accompanied by tumor deposits in the bronchial and mediastinal lymph nodes.<sup>15,16</sup> These studies also represent metastases from metastasis since lymph node drainage is specific for the small bowel or lung. It has been reported that



*Although the medical literature does suggest metastatic tumors can produce further dissemination of cancer cells, reports are sparse and the data are inconclusive.*

blockage of lymphatic drainage can result in a retrograde lymphatic embolization of tumor.<sup>17</sup> This route of spread appears to be very unlikely in this patient. If mediastinal lymphatic blockage did occur, it would be expected to result in disseminated retroperitoneal metastasis not isolated metastases to the small bowel and the mesenteric lymph nodes. No case of an isolated small bowel mesenteric lymph node metastasis from a lung primary has been reported.

Although autopsy examination has demonstrated metastases to the small bowel to occur in 11 percent of patients dying from cancer, patients rarely present with symptoms associated with the small bowel metastasis.

Our patient represents the 16th reported case of a lung cancer metastasis to the small bowel presenting clinically.<sup>18</sup> It represents the only case of an undifferentiated cancer of the lung presenting as an isolated metastasis to the small bowel. The majority of patients present with small bowel perforation and rarely with a significant hemorrhage.

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## DRUG TESTING OF STUDENT ATHLETES: A POLICY CONCERN

Donald Louria, MD

*Health care professionals should inform policymakers about sensitivity and specificity; predictive values of positive and negative tests; and false positives in low prevalence areas.*

**Dr. Louria is professor and chair, Department of Preventive Medicine and Community Health, UMDNJ-New Jersey Medical School, Newark.**

By a 6-3 vote the Supreme Court recently upheld suspicionless and random drug testing for student athletes.<sup>1</sup> Athletes were singled out because they are considered role models for the rest of the student body. The decision creates major policy concerns.

Our Constitution does not guarantee privacy, nor do any amendments to the Constitution. However, the Fourth Amendment embodies language that has been utilized to protect certain aspects of individual privacy. The Fourth Amendment states, "The rights of the people to be secure in their persons, houses, papers, and effects against unreasonable searches and seizures shall not be violated and no warrants shall be issued but upon probable cause, supported by oath or affirmation and

particularly describing the place to be searched and the persons or things to be seized."

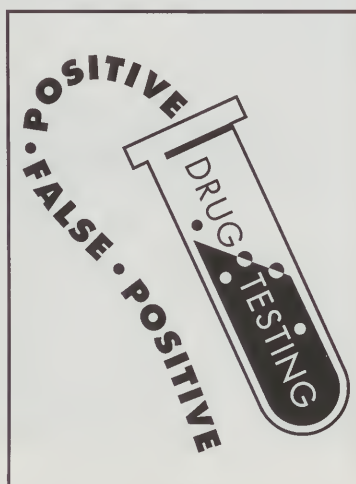
Student athletes were said to have less expectations of privacy because they are volunteers, because "school sports are not for the bashful," and because athletes suit up before practice in communal locker rooms and

letes now gives sanction to widespread urine, blood, or breath testing for virtually any student or employed individual.

The stated or implicit goal of drug testing is an achievement of a drug-free society. There is nothing wrong with the goal of a society free of mood-altering or performance-enhancing drugs. The question is: "What price are we willing to pay in order to achieve conformity?" Those favoring testing to achieve a drug-free society support this goal by arguing that preventive (suspicionless) drug testing can produce benefits in the following areas:

- *Increase productivity and decrease absenteeism.* However, data are limited, uncertain, and unconvincing.<sup>24</sup> It is not clear at all that the type of drug use detected in a suspicionless search has anything to do with productivity, absenteeism, employment duration, or promotions.

- *Promotion of health.* Data are not adequate. If someone is addicted or habituated, detec-



take showers in communal facilities.<sup>1</sup> According to the majority opinion, taking a shower in the presence of others reduces expectations of privacy and Fourth Amendment protections. The decision of the Court in regard to student ath-



## *Medical educators can play an important role by modifying curricula to incorporate issues at the interface of medicine and science on one hand and the greater society on the other.*

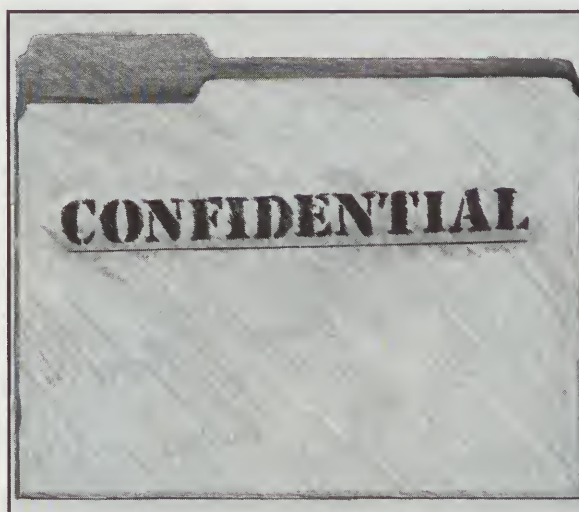
tion can promote health but those situations are subsumed under the rubric of testing for reasonable suspicion or probable cause. There is no evidence that those users detected by suspicionless searches are any less healthy than peers, their colleagues, or fellow employees.

- *Safety of coworkers or the general public.* Even in the absence of good epidemiologic data for any drug except alcohol, common sense and the alcohol data justify random drug testing of certain groups but there are no data that would justify random drug testing of athletes at any level for safety reasons.<sup>5</sup> Potential rage reactions due to cocaine or amphetamine (or steroid) usage could endanger other athletes, but theoretical concerns about safety in athletic competition should not be applied to student athletes in the absence of any credible epidemiologic evidence.

- *Detection of users who then can be provided with assistance.* The term assistance often is deliberately unexplicated. In other cases, it is defined as referral for treatment. There are treatments for heroin addiction that help some motivated

individuals. But there is no known effective treatment for the recreational user of any drug. There also is no predictably effective treatment for heavier use of marijuana, cocaine, amphetamines, or LSD.<sup>6,8</sup>

Many of the assumptions underpinning drug testing policy are shaky and are inadequately supported by convergent epidemiologic evidence.



There also are problems inherent in implementing drug testing programs. This is a critical issue that constantly is downplayed by technologists. But it will not go away. Split specimens will not overcome the problem of specimen mislabeling. Certain foods can give

false positive results.<sup>9,10</sup> The predictive value of a positive test for marijuana or cocaine may not be satisfactory.<sup>11</sup> Students mislabeled as drug users may suffer humiliation, be ostracized, or removed from competition; and it may be very hard to convince administrators that the test result is a false positive.

There are multiple other implementation issues:

- Urine tests will detect some medications the student may not wish to reveal to the school.

- Urine tests have quantitative cut-offs. Whose quantitative cut-off will individual schools use?

- As drug testing programs proliferate, will quality control be maintained? The usual proficiency tests are not sufficient because the laboratory knows they are dealing with proficiency tests. What is needed are blinded proficiency tests submitted as if they were routine patient specimens.<sup>12</sup>

## *As drug testing programs proliferate, will quality control be maintained? Proficiency tests are not sufficient because the laboratory knows it is dealing with proficiency tests.*

There are huge problems in implementation of drug testing policies, led by coping with consequences of false positives.

Every court decision reducing Fourth Amendment privacy rights in the last 30 years has presaged a further incursion. The extraordinary advances in communications and information technologies already have left us with scant ability to keep our personal data to ourselves.<sup>13</sup> What does the current decision imply for the future? There are two major concerns, one more narrowly based on this decision, the other focused on our technologic capabilities.

First, since the Supreme Court decision is not grounded on persuasive epidemiologic evidence, there will almost surely be a continuing impetus for broadening the scope of testing to achieve the underlying goal of societal conformity in regard to use of mind-altering drugs in the absence of adequate scientific evidence.

Second, the decision encourages acceptance of and widespread dissemination of intrusive biomedical technologies that will allow interested parties to learn a great deal about

other people with or without their acquiescence, much of which, heretofore, has been considered inviolate personal information. Thus, this decision must be viewed in the broader context of our burgeoning biomedical technologies and the direction that sophisticated analyses of body fluids or cells might take us in coming decades.

The greatest concern, in this regard, relates to the implications of deciphering the human genome.<sup>14</sup> Genetic information on current or potential employees would be of great interest to employers; similar data on students could be used by school administrators for classification purposes. Genetic analysis will be justified using the same rubrics employed for drug testing—safety, productivity, health, and early intervention in medical or psychological problems.

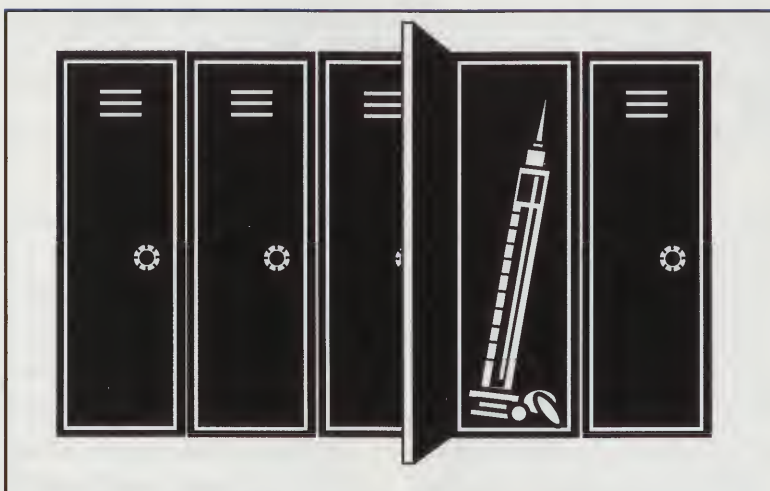
The medical profession must be more involved in policy decisions about drug testing for the following reasons: drug abuse is considered a health problem and those testing positive often are referred to health care workers for rehabilitation or assistance; the long-term consequences of approving

widespread body fluid testing will involve testing in other circumstances that directly impacts on medicine, science, and health; and health care personnel will have to handle the psychological consequences of false positive results. Additionally, we should be concerned that policy decisions are being made in the absence of careful analysis of available epidemiologic and statistical data.

How can the medical profession become more involved? Formal medical organizations could be more vigorous in researching relevant questions and available data, taking public stands on the issues, and testifying before congressional committees; medical organizations, collaborating with lawyers, could submit amicus briefs to the courts.

As individuals and organizations, health care professionals should take the lead in informing policymakers about sensitivity and specificity; predictive values of positive and negative tests; and the issue of false positives in low prevalence areas. Individual physicians can become informed and then write to newspapers and congressional representatives.





Medical educators can play a particularly important role by modifying curricula to incorporate issues at the interface of medicine and science on the one hand, and the greater society on the other.<sup>15</sup>

We now are utilizing technologic advances to conduct ever more sophisticated internal body searches. In doing so, we have trampled on individual rights to privacy and have undercut the Fourth Amendment, all in the name of the good of the greater society, and in so doing we have endorsed actions that many would feel are antithetical to some of the very precepts on which American democracy is based. Given these trends and our biomedical technologic cornucopia, it is very likely that in future years there will be additional loss of privacy with resulting implications for the general public and the health care profession.

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ADVANCES

# THE EMOTIONAL IMPACT OF MS DIAGNOSIS

Ruth Velikovsky Sharon, PhD  
Alfredo Sadun, MD, PhD

*The physician has significant emotional impact on the patient and communication variables can take on great importance in the early phase of a physician-patient relationship.*

**A Princeton resident, Dr. Sharon is in private practice. She is a noted author and consultant for television interview programs. Dr. Sadun is professor of ophthalmology and neurosurgery at USC School of Medicine.**

There is an increasing awareness in medicine of the impact of emotional states on the condition of patients. Stress and depression often enter into a vicious cycle with physical illness. The experience of illness is a source of stress and depression; in turn, stress and depression contribute to the severity of the symptoms of the illness and complicate effective management and treatment. The patient's emotional state also can play a positive role in combating illness. It has been observed that what keeps a seriously ill patient from crossing over the dividing line

between life and death may be the will to live.<sup>1</sup>

In a medical system in which mental and physical health are divided into separate professions, increasing awareness of the involvement of emotional health in physical health has resulted in referrals from physicians to mental health practitioners for treatment. By developing a greater understanding of the emotional concerns of the patient, the physician can better serve patients and avoid pitfalls that will emotionally derail patients.

The period surrounding the diagnosis of an illness is a sensitive one. Before an accurate diagnosis is established, a period of uncertainty exists. From a psychological perspective, this uncertainty may give the patient the freedom to hope. Later, the presentation of a diagnosis will chain the patient's emotions to what the physician presents as the truth. This may lead the patient into a new relationship with the physician, whereby the patient puts

body and mind under the entrusted care of the physician.

In a situation in which the patient's diagnosis cannot be addressed with certainty, a physician might choose to give a patient information, such as citing statistics for the range of medical possibilities. The competent doctor desires to meet the patient's expectations. However, the question arises whether such information always is appropriate to the patient's emotional state. The physician has significant emotional impact on the patient, and subtle communication variables that fall under the domain of "personal style" take on greater importance in this phase of the doctor-patient relationship. Although the physician is earnestly working for the patient's welfare, the presentation of medical information can mobilize reactions in the patient that may hamper productive communication and treatment.

The physician plays a major role in the emotional reaction of the patient. If a patient devel-



*The clinical definition of MS is based on a patient having two or more severe and completely different neurological symptoms reflecting brain lesions at two or more different times.*

ops a fear response when given medical information, the patient will become resistant to the information and will not be able to effectively cooperate with the physician in the treatment of the illness or management of the symptoms.<sup>2</sup>

The interaction with the physician, more than anything else, will determine whether a patient develops a fear response to a diagnosis. It is important not to underestimate the potential upset a patient may experience in coming to the physician for a diagnosis. The impact of the physician's presentation of the diagnosis can set the tone for the patient's reaction to the entire course of treatment.

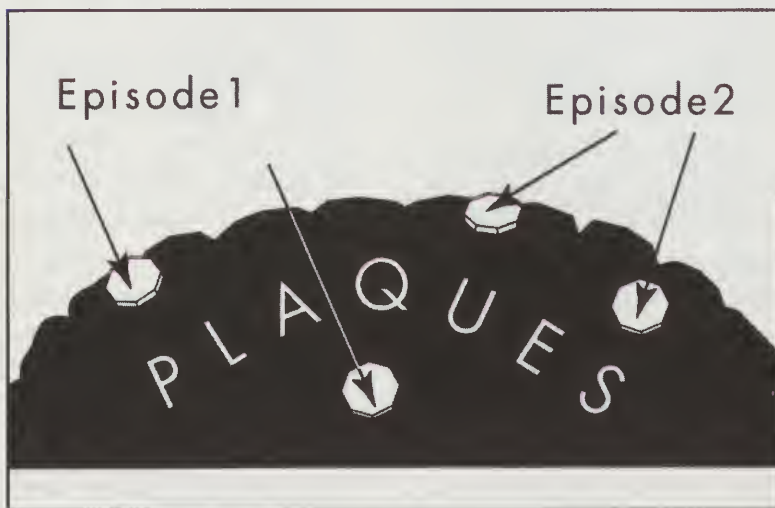
In some cases, the interaction with the physician may trigger intolerable feeling causing the patient to break contact with the physician, refuse treatment, or turn to alternative medicine.<sup>3</sup> It is essential that the patient retain a positive emotional stance, and it is the responsibility of the physician to foster such an attitude in the patient by avoiding counterproductive communications.

*A case report.* Optic neuritis has a relationship to multiple sclerosis (MS), but it is a relationship that very often is misunderstood by physicians, and, therefore, by patients.<sup>4</sup> Both diseases are on a continuum. On one end of the spectrum is blatant MS: progressive, severe,

and disabling. On the other end of the spectrum is asymptomatic MS, in which a person has no neurological symptoms. Optic neuritis usually falls into a middle range where the patient may never experience further problems, may develop classical MS (usually a mild form), or may experience some neurological symptoms but is able to pursue life without disability.

If autopsies were performed on the brains of "normals" (people who never experienced neurological problems), with samples taken about every inch, 4 percent of the samples would have plaques, the scientific marker for MS. If samples were taken approximately every one-half inch, 7 percent of the patients would have plaques. If such brains were sliced finely enough, it would be possible that most samples might have microscopic plaques.<sup>5</sup>

Hence, an anatomic or scientific definition of MS is not very useful to the patient. It does not assist with treatment choices and it does not help with diagnosis or prognosis. On the emotional level, the patient wants to know, "Am I



*It is prudent for the physician to be very careful about raising the possibility of MS with a patient; the rate of misdiagnosis of the disease is as high as 30 percent.*

going to be the person in the wheelchair?" To answer this question, the doctor must rely on a clinical definition of MS, which is much more useful. The clinical definition is based on a patient's having had two or more severe and completely different neurological symptoms reflecting brain lesions at two or more different times, separated "in space and time."

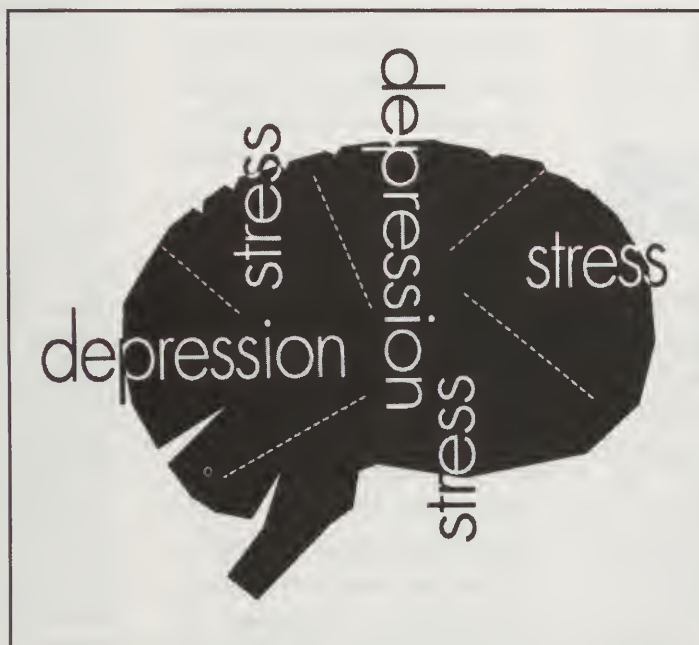
Magnetic resonance imaging (MRI) can be used to evaluate a patient for MS. Unfortunately, MRI can lead to more confusion and panic because great numbers of patients who had never shown MS symptoms demonstrate plaques on MRI scans. Both doctor and patient may interpret these plaques as the doorstep of MS; however, recent studies report that MRI is not a reliable predictor of the future development of MS in patients with optic neuritis.<sup>6,7</sup> Most patients with optic neuritis

do not go on to full-blown MS. If the criteria for an MS diagnosis were based on having plaques on MRI, then as many as 90 to 95 percent of optic neuritis patients might be con-

sidered to have MS. Hence, researchers warn that "a conservative approach to the interpretation of MRI must be taken at this time. We must avoid allowing MRI to provoke false positive diagnoses. The clinical diagnosis of MS, even though only 95 percent accurate, must remain the gold standard."<sup>8</sup> It may seem reasonable for a physician to describe to a patient the relationship between the plaques seen on the MRI report and the potential for MS, but, in the absence of neurological symptoms, the physician should consider whether this information can be usefully assimilated by the patient. It is prudent for the physician to be very careful about raising the possibility of MS with the patient. The rate of misdiagnosis of the disease is as high as 30 percent.<sup>9</sup> The strict criteria for diagnosis should include at least two incidents of blatant and distinct symptoms; any discussion of the disease with-

out this evidence can only be considered speculative. A patient who is diagnosed incorrectly can suffer a serious emotional shock, one that may complicate the treatment of the actual source of the patient's symptoms.

Introducing the possibility of an MS diagnosis will oversensitize the patient to routine aches, numbness, and tingling





*Studies have shown that the incidence of suicide in MS patients correlates more closely with the time of diagnosis than with the time of onset of the disease.*



in the body. Every experience of discomfort will fuel the fear of developing debilitating MS. For a patient who does have a minor neurological complaint, the fear of contracting MS makes it difficult to adjust to the actual malady. This situation breeds stress and depression.

For patients with newly diagnosed optic neuritis, the relationship between the two diseases should be raised in a manner that stresses the distinction between laboratory evidence of MS and the clinical diagnosis that has prognostic meaning. In addition, it should be emphasized that if optic neuritis later develops into MS, it usually is of the mildest form of the disease.<sup>10,11</sup> The informa-

tion should address the patient's emotional need to plan for the future, to have a career, or to get married and have children. Frequently, optic neuritis patients are simply informed that their MRI reveals plaques that are associated with MS. Although a small minority of cases will become serious MS, it is ill-advised to leave a patient in a state where fear will dominate, throwing the patient's emotional state into disarray.

Attention has been given in the medical literature regarding suicidal tendencies in MS patients. Studies have shown that the incidence of suicide in MS patients correlates more closely with the time of diagnosis than with the time of onset of the disease.<sup>12</sup> The period of greatest risk, according to the investigation, is the first five years after diagnosis.<sup>13</sup> This suggests, hauntingly, that interacting with the health care system itself played a role in the patients' choice to end life. While suicide in some instances may indicate a failure by the medical profession in responding to the needs of these patients, the authors of one study warn that "suicide is

an extreme solution for the patient and may only be the tip of the iceberg. An additional number of the MS patients may have suffered from serious depression because of their disease."<sup>13</sup>

Medical professionals may not only be overlooking signs of serious depression, they also might be inducing depression due to their poor communication. This is important to consider since other studies have indicated that stress and depression interfere with the effective management of MS symptoms, and actually may contribute to episodes in the progression of the disease.<sup>14</sup>

Underscoring the emotional nature of this disease are findings that various forms of psychotherapy can reduce severity of MS episodes or slow the progression of the disease.<sup>15</sup> Judging by the current literature, there is an encouraging trend to explore psychological avenues in the treatment of MS.

A physician must consider the emotional character of each patient and be careful not to provide information at a time and in a manner that might undermine a patient's emotional well being. This is not an

*As the doctor-patient relationship strengthens over many visits, information may be provided to the payer layer by layer; as each layer is assimilated the patient understands the truth.*

argument for hiding or obscuring information from the patient. Rather, this is a call to examine the psychological impact of the personality of the physician and medical information delivered, particularly during the diagnosis phase. As the doctor-patient relationship strengthens over many visits, for the sake of honesty and to prevent the patient from hearing it "on the street," information may be provided to the patient, layer by layer. When one layer of information is properly assimilated, the patient can understand the next truth. The ideal doctor-patient communication requires not only the doctor's expertise, but also the doctor's sensitivity to the emotional vulnerability of the patient facing chronic disease such as optic neuritis and MS.

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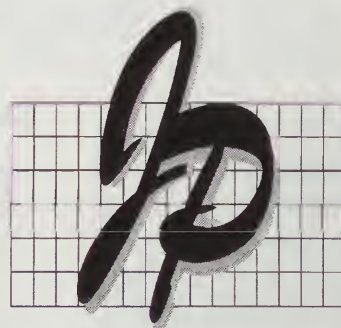
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# COMMENTARY

## New Jersey health care enters the electronic age

*Commissioner  
Len Fishman*

A Trenton internist confers with a Newark neurologist without picking up the telephone. An emergency room physician learns that an unconscious accident victim has diabetes and heart problems. A local doctor administers antibiotics in a school, hours after a case of meningitis is diagnosed. A legislator knows a new law governing health care standards is working weeks after it was enacted.

This isn't ad copy from a computer magazine, but a glimpse of what New Jersey residents can expect as the New Jersey State Department of Health (DOH), hospitals, physicians, and other health care providers move into the information age. Some of these applications are farther down the road, but some are here now. And they are making a difference.

The next century's infrastructure won't be made of asphalt, concrete, or steel girders, but of fiber optics, cable, and microwaves. These roads won't carry goods or people, but information. For our health care providers to flourish in the next century, we need to shepherd that information through pathways that improve public health.

To do that, we need an electronic data network, a network that will allow us to gather, share, and manage information. We envision a health information network connecting hospitals, doctors' offices, HMOs, insurance companies, public health clinics, pharmacies, local health departments, and individual health care consumers through their personal computers. Ultimately, a data network will reduce cost, increase efficiency, and give us insight into how to improve the health of our residents. We are laying the foundation for that network now. But before I tell you about where we're going, let me tell you what we've done.

Our electronic birth certificate program, which should be in most of our hospitals by summer 1996, has yielded data that show women are benefiting from a new law that says insurance companies must cover maternity stays of 48 hours for a normal vaginal delivery, and 96 hours for a caesarean section. We know that by



looking at the length of stay of mothers who had noncomplicated deliveries. Electronic birth certificate data showed the average length of stay for normal delivery increased significantly from 1.3 days to 1.9 days since the law was signed last June.

Before the electronic birth certificate system, it would have taken a year to gather that information. We were able to know about length of stay in one day, just by asking the question.

We can learn about mothers' prenatal care, what type of delivery they had, and whether their babies were at risk for birth defects. Hospitals, too, can use this information. They can use data on caesarean sections for quality assurance programs.

With this system, we will be able to search databases so we can better target resources. The information we received will help make changes in the advice we give to health professionals and the public.

We also are expanding our state's electronic immunization registry. This registry will enable doctors to know when children have had their immunizations and which children need them. Right now, too many opportunities are lost to vaccinate children because their immunization history is missing.

We also have taken our cancer registry from a paper-based system to an electronic one. Seventy percent of our hospitals are reporting electronically, and DOH is distributing software to the remaining hospitals to help make the system more timely.

Data will allow DOH to perform outcome measures that will help better evaluate the quality of health care in the state. Our proposed HMO regulations will require HMOs to report health outcomes, making us among the first states to require this information. With the information, we can see whether HMOs are making good on their promise of preventive care.

We will know what percentage of children enrolled in HMOs are immunized before their second birthdays. We will know how many pregnant women receive prenatal care during their first trimester and how many women over the age of 50 get mammograms. We will know how many children with asthma were hospitalized and how many diabetics had retinal exams. Eventually, we will be measuring outcomes of selected surgical procedures among HMO patients.

Outcome measures also will show employers and their workers how well their HMOs are performing. Right now, consumers, employers, and health professionals do not have much information, except for anecdotes, to make judgments about individual HMOs. By looking at consumer satisfaction surveys from all HMOs, workers and employers will know how promptly HMO customers get appointments or how easily they get specialty care when they need it.

New Jersey is 1 of 13 states to be recognized by the Centers for Disease

## COMMENTARY

# COMMENTARY

Control and Prevention (CDC) for its Information Network for Public Health Organizations project. The CDC has committed funds for us to design an electronic network for the prompt transmission of information on communicable diseases and other threats to public health.

The CDC made it clear to us that the New Jersey Legislature's commitment to health information technologies influenced it to commit those federal funds. We hope we've made our commitment as clear.

Much of the inspiration for the advancements I've outlined comes from Senator Littell who has challenged us to use the evolution of electronic data interchange technology to make our fragmented health care system work better for residents.

Senator Littell worked with the New Jersey Institute of Technology and Thomas Edison State College to produce the Health Improvement Network Technology (HINT) Report, which has been translated into nine bills working their way through the Legislature.

A critical issue addressed by one of those bills is patient confidentiality. Exchanging information sounds great until you realize it might be your infor-

mation that is exchanged. Senators Littell and LaRossa realized the potential for the loss of confidentiality with a data network and they set out to address that issue. One of the bills calls for penalties for the unauthorized use, disclosure, or sale of individual, identifiable medical information.

The potential health benefits from an electronic data network are considerable and so are the savings. The HINT Study Commission concluded that \$750 million could be saved if all

health providers eliminated paper transactions and converted to electronic information systems. The HINT Report also found that on average, 85 percent of claims still are filed on paper.

An electronic data network will make for the prompt payment of insurance claims, which is certain to improve cash-flow for physicians, hospitals,

and other health care providers. It also will mean standardized insurance claims, something health care providers have been supporting for years.

In the end, the real winners in these high-technology connections are patients, who are already in cyberspace, gliding across the internet, using this fast-paced information for education, hobbies, and fun. They will be glad to know the field of health care won't be left behind.



*Commissioner Len Fishman*



# DO YOU HAVE THE RIGHT TIME?

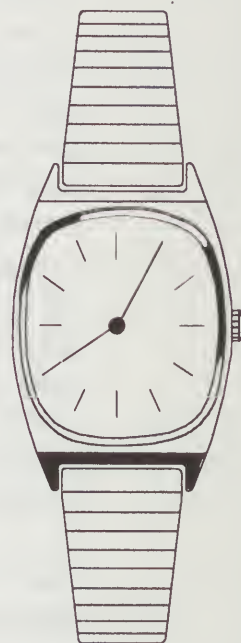
It's 9:40  
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you felt a sharp  
pain in your right  
arm and side ...



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## PROSTATE CANCER: ESSAYS ON DECISION MAKING

Don Kissil

*Physicians need to be more aware of their patients' sense when they deliver the news of prostate cancer. And the patient must make the treatment decision.*

will receive the same news in 1996 alone and more than 41,400 men will die.

From the literature, I know that in a man over the age of 50 years, clinical symptoms for prostatic disease (not necessarily cancer) are primarily: a diminished urinary stream and/or an increased urinary urgency. The appearance of these prompted me to visit my urologist. He took a wide battery of blood tests including the PSA, and performed the DRE.

For the past three years his diagnosis had been benign prostatic hypertrophy and thus each year, as I left his office with his stern warning to "come back and see me in six months or if your symptoms change," I did not. My work kept me so engaged that I'd skip it with the justification: "Ah, I'll catch him at my next annual."

At that next annual, he repeated the DRE and took another PSA, checking the prostatic velocity. This translates into: if my PSA had risen sharply and/or now was higher than 6.0, he'd tell me I'd need more tests. These would include a TRUS and a prostatic

"So," my urologist asked, "what are you going to do?" I'm 61 years old, and just got word that I have prostate cancer. Reasonably certain that I should not kill the messenger as I tried to understand his message, I am shocked, and virtually unable to cope. But I'm not a rare case. More than 317,000 men

*Cancer treatment can be confounding, requiring a complex decision-making process selected from a perplexing variety of options.*

the increasing complexity of modern medicine, in an era of rapid change and high technology, places extraordinary demands on patients at a time of great vulnerability.

Cancer treatment, in particular, and, perhaps mostly so for prostate cancer, can be confounding, requiring a complex decision-making process selected from among a perplexing variety of options, some of which may appear equivalent.

How may patients deal with such vagaries, and how may they best make choices in the context of such uncertainty?

Three aspects of patient care form the foundation of coherent patient management: communication, attitude, and support.

Successful patient care depends on effective and sensitive communication between an involved, compassionate physician and a concerned patient who may be apprehensive about his health and what the future may portend.

Effective communication requires an understanding and appreciation of the responsibilities of both

Few experiences in life are more stressful than learning of a cancer diagnosis. Implications for shortened survival, disruption of personal and family circumstances, and discomfort of illness can create havoc, if not panic, making it difficult to retain objectivity and to exercise rational choice and discretion in treatment options. Further,

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## Kissil

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biopsy to check for cancer. My PSA had risen from 3.86 to 6.85 in about a year and only then did I begin to get frightened.

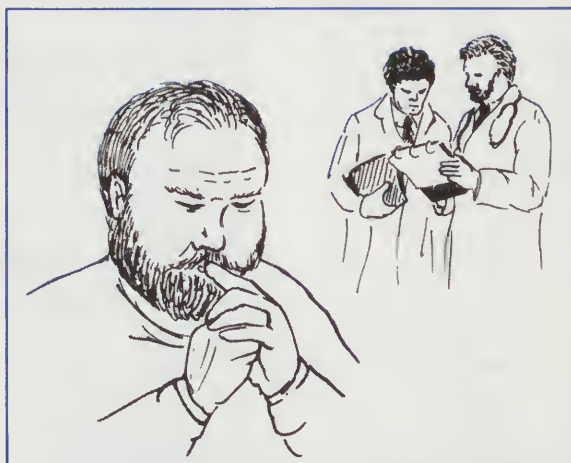
When my biopsy report was positive, with a Gleason score of 5, it was then that I went ballistic. A firm believer in second opinions, I had my Gleason reread. It came back a 4, with the "explanation" from the doctor something like, "You see, Don, the Gleason score is somewhat subjective. . . ."

Although he sat across his desk from me, when my urologist spoke, I heard him as if he were a mile away.

"There is no need to panic, big guy. You have essentially four courses of action. One, is a radical prostatectomy, which I can do. Two, is either internal or external radiation, that's done by a radiation oncologist. Three, involves the use of hormones to shrink the prostate followed by either of the above two radiation techniques. Four, is watchful waiting where, because statistically, this cancer is so slow growing, I will do another PSA and biopsy in 6 months and then you can decide."

Thus began my odyssey through a morass of conflicting expert opinion, best clinical judgments, statistical gibberish, and a decision-making process that could test the wisdom of Solomon. Those next months devoured a good piece of my intellect, my native intelligence, and a bit of my faith.

A detailed discussion with my wife, preceded my first visit to a prostate cancer support group called *US TOO*. Here too I met men who had already made, or were about to make, the same decision I ultimately would. Here I found answers to questions I never even thought of asking. I learned scads of exotic words like: staging, T scale, RT-PCR, MEV, nerve sparing, impotence, positive margins, coil-MRI, lymphectomy, pericapsular, prostatic volume and densi-



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## Lippman

*continued from page 57*

parties involved in the physician-patient interaction. A principal function of the clinician is to impart understandable information in a constructive and hopeful manner. The patient, in turn, is expected to receive and assimilate this information and to interact further by seeking clarification of issues that may be unclear or incomplete.

An important benefit of effective communication is the establishment of trust. This leads to improved patient compliance with treatment recommendations, meaningful informed consent, and enlistment of the patient in the treatment process. Ineffective communication produces decreased efficiency of patient care, patient resentment against the

physician and other health care professionals, and loss of credibility, thus damaging the professional image of the physician.

One consequence of the physician's failure to achieve effective communication may be an erosion of medicine's values, perhaps leading to profound social changes affecting the delivery of care. Enter managed care—considered by some a threat to physician autonomy and a barrier to effective communication.

A second aspect of patient care, impacting on the decision process, is attitudinal. In recent years, attention has been focused on the psychological responses to cancer and the influence of attitude toward cancer and outcomes. Some studies have shown that those who exhibit a "fighting spirit" and who take an active role in planning and executing treatment options, can optimize opportunities and frequently survive longer, with a better quality of survival. On the other hand, those who may be apathetic, give in to hopelessness, or who manifest depression, may

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## Kissil

*continued from page 58*

ty, DNA ploidy, and LHRH. I read reams of reports in the medical and lay press. And in time I knew those words and numbers, along with their statistical analyses as well as I knew my own street address. But no one at US TOO told me what I should do.

My urologist, however, had no hesitation in this regard. He told me exactly what I should do. And that was to have the radical surgery, performed by him.

The radiation oncologist also explained it all. He tested and provided additional statistical analysis, and we talked at length, but in the end, I was still unable to make a decision. He, of course, had little trouble telling me what I should do—as did every physician with whom I spoke.

And my anxiety level grew, for the issue here was clearly not the cancer but rather how I, as a patient, i.e. a mature, decision-oriented man, make a rational therapeutic decision, when all the experts do not agree.

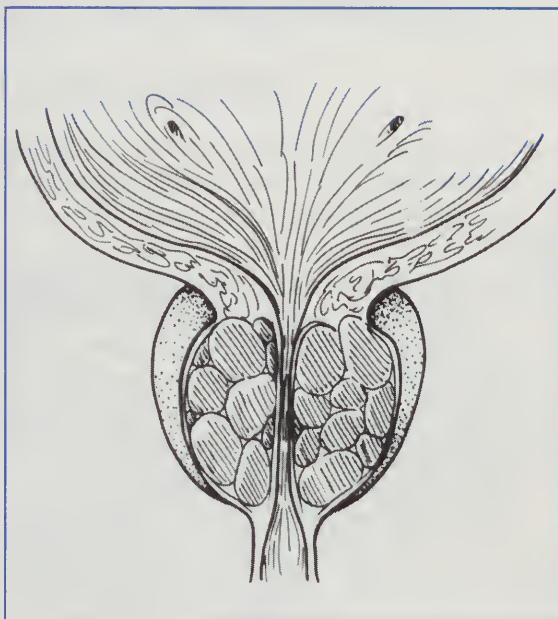
Each physician I visited, as well as most discussions with male colleagues who had prostate cancer, provided me with such wonderful success stories, that I usually left feeling certain that this last therapeutic approach was, undoubtedly, my best course of action. This perplexing info-babble continued for more than three months and what became clear was, that if all the experts did not agree, I needed some medical objectivity.

That impartiality came not from a surgical oncologist nor a radiation oncologist but from a medical oncologist. His advice provided the clarity I needed to make an informed decision, when all the gods could not agree.

The medical oncologist said that based on the staging of my cancer, my age, and my lifestyle, the 10-to-15-year survival statistics for both the radical surgical approach and for the 3D “conformal” external radiation approach were equal and good.

This was from a physician who had been seeing patients for almost 40 years, and who, as I predicted, preferred the newer hormonal treatments available today, but to my surprise said that in my specific case, hormones would not appear to hold any additional benefits.

“So,” he said with an avuncular smile, “the choice is still yours. You need to decide and then act.”



©Beth Starkey

“What about this watchful waiting I’ve read about?” I asked.

“Well,” he responded, “that’s part of your decision too. Some men, when they hear they have cancer, no matter how slow growing it’s supposed to be, can’t wait to get rid of it. Other men will play the odds—depending on their age, general health, etc.—and wait. I could never really understand for what they were waiting. Their cancer is not going to go away. I guess it really comes down to a staging question. And at your stage of the disease, I don’t see any advantage in waiting. Go home, think about it for a while and make a decision.”

And I did just that. I chose external radiation, and almost a year post-treatment, I’m still comfortable with my decision. But my decision is not meant to influence anyone. It was based on my lifestyle, my staging, and my age, and lots of thinking and praying. Because whether or not the medical gods agree, treatment decisions ultimately belong to their patients; and physicians need to be more aware of their patients’ sense when they deliver news of prostate cancer. As I think back, US TOO was perhaps the most valuable tool I had in my decision-making process. That’s precisely because they did not tell me what I should do. I’ve also concluded that even though the patient must make the decision, he must know too, that the final outcome of his decision, remains with God, not man.

**NJM**



## Lippman

*continued from page 58*

have a shorter survival. Stress, attitude, mood, and immune function all have been thought to play roles in the psychological reaction to cancer and in outcomes.

Little firm data exist to support these contentions, however, and further corroboration of the observations with fuller understanding of the physiologic relationships among stress, emotional temperament, endocrine mechanisms, and immune function must come before full acceptance, but the relationships are intriguing and the implications are far-reaching.

The third aspect of care is support. Modern cancer treatment programs, in addition to providing high-quality medical care, innovative techniques, and high-tech interventions, have become more patient-centered, addressing emotional as well as physical needs.

This integrated approach seeks to address patients' personal needs through advocacy, patient representation, and attention to individual rights. Dealing with the concerns of families and enlisting their cooperation and support also is deemed essential to the delivery of high-quality care. Efforts to lessen patients' fears and frustrations eases the delivery of cancer care.

Integrated care of the cancer patient involves a multifactorial approach. Primary medical care is augmented by a system providing direct patient support in the form of patient advocacy and the provision of patient relations and social services. Attention to the treatment environment and the recognition and fulfillment of supplementary health education services through outreach programs also are deemed crucial.

The new high level of complexity of the health care system, particularly cancer care, tends to fragment the delivery of medical services and undermine continuity of treatment programs. Patient relations programs and a wider scope of professional health care personnel, such as oncology nurse clinicians, have been introduced to address the needs. Patient relations programs are established to offer guidance and support, to facilitate understanding of treatment strategies, and to modulate misunderstandings or grievances. Professional patient relations services can assist in the preparation of advance directives, durable powers of attorney, or other legal services.

Coordination of home or facility support services, including hospice services, is another example. Other matters addressed include language interpreter services and spiritual support through chaplaincy services. Clinical social work services encompass such activities as individual and family assessment and counseling, provision of educational and informational materials, and creating and maintaining support groups.

This additional dimension of clinical care has been shown beneficial from the standpoint of reducing anxiety, depression, and pain for at least some patients. Liaison with community agencies and external support services represents an important link in the process of providing comprehensive cancer care.

Recognizing the role played by the treatment environment in the care of cancer patients, many medical facilities have established treatment units designed to promote comfort and emotional reassurance. Ambulatory care facilities and short-stay inpatient units, simulating the home environment, serve to reinforce the emotional support necessary for patients and families in an otherwise unsettling time.

Finally, extended informational services provide yet another level of support for patients and families seeking further information beyond the local cancer treatment center. The National Cancer Institute's Cancer Information Service (1-800-4-CANCER) provides patients, families, and the general public with immediate access to current disease-specific information and latest treatment options. The Physician Data Query system allows professional and lay communities access to information regarding a broad range of treatment options.

As the professional who operates as the overall coordinator for the patient's treatment program, the medical oncologist has an essential role. No longer simply the chemotherapist who delivered cytotoxic therapy in an often futile gesture, the medical oncologist has become the team leader offering comprehensive and far-reaching services and support for the cancer patient.

The medical oncologist does not treat cancer, the medical oncologist treats cancer patients.

**NJM**

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**MAY '96**

**MONTHLY DERMATOLOGY  
MEETING**

**MAY 14, 1996**

Schering Corp., Kenilworth  
(*Dermatological Soc. of NJ*)

**SOCIETY OF  
ANESTHESIOLOGISTS**

**MAY 14, 1996**

Somerset Marriott Hotel, Somerset  
(*AMNJ*)

**USE OF NEWER  
CARDIAC DRUGS**

**MAY 15, 1996**

St. Mary's Hospital, Passaic  
(*AMNJ*)

**INTERHOSPITAL ENDOCRINE  
ROUNDS**

**MAY 15, 1996**

University Hospital, Newark  
(*AMNJ*)

**MEDICAL GRAND ROUNDS**

**MAY 15, 1996**

VA Medical Center, East Orange  
(*AMNJ*)

**DIABETES IN PREGNANCY**

**MAY 15, 1996**

General Hospital Center at Passaic  
(*AMNJ*)

**FAMILY MEDICINE  
SERIES**

**MAY 15, 1996**

RWJ Med. School, Camden  
(*Cooper Hospital*)

**DIABETES CERTIFICATE  
PROGRAM**

**MAY 18-19, 1996**

Meadowlands Hilton, Secaucus  
(*Center for Pharmaceutical Care*)

**TRANSFUSION MEDICINE AND  
STEM CELL TRANSPLANTATION**

**MAY 22, 1996**

RWJ Med. School, New Brunswick  
(*UMDNJ*)

**HEAD & NECK ONCOLOGY  
AND RADIATION ONCOLOGY**

**MAY 22, 1996**

The Manor, West Orange  
(*AMNJ*)

**NEPHROTOXICITY OF  
COMMON DRUGS**

**MAY 22, 1996**

St. Mary's Hospital, Passaic  
(*AMNJ*)

**INTERHOSPITAL ENDOCRINE  
ROUNDS**

**MAY 22, 1996**

University Hospital, Newark  
(*AMNJ*)

**MEDICAL GRAND ROUNDS**

**MAY 22, 1996**

VA Medical Center, East Orange  
(*AMNJ*)

**ALLERGY MANAGEMENT**

**MAY 29, 1996**

General Hospital Center at Passaic  
(*AMNJ*)

**INTERHOSPITAL ENDOCRINE  
ROUNDS**

**MAY 29, 1996**

University Hospital, Newark  
(*AMNJ*)

**MEDICAL  
GRAND ROUNDS**

**MAY 29, 1996**

VA Medical Center, East Orange  
(*AMNJ*)

**DIABETES CERTIFICATE  
PROGRAM**

**MAY 18-19, 1996**

Meadowlands Hilton, Secaucus  
(*Center for Pharmaceutical Care*)

**NJ GASTROENTEROLOGICAL  
SOCIETY**

**JUNE 5, 1996**

The Manor, West Orange  
(*AMNJ*)

**DIAGNOSIS & TREATMENT  
OF HEADACHE**

**JUNE 5, 1996**

General Hospital Center at Passaic  
(*AMNJ*)

**MULTIPLE ANTIBIOTIC -  
RESISTANT BACTERIA**

**JUNE 5, 1996**

St. Mary's Hospital, Passaic  
(*AMNJ*)

**FRONTIERS IN BIOMEDICINE**

**JUNE 5, 1996**

Corning Clinical Laboratories, Teterboro  
(*AMNJ*)

**OB/GYN ANNUAL MEETING**

**JUNE 7-8, 1996**

Trump Plaza Hotel, Atlantic City  
(*AMNJ*)

**NON-HODGKIN'S  
LYMPHOMAS**

**JUNE 12, 1996**

St. Mary's Hospital, Passaic  
(*AMNJ*)

**CANCER UPDATE: RESEARCH &  
BEDSIDE PRACTICE**

**JUNE 12, 1996**

Somerset Marriott, Somerset  
(*AMNJ*)

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### MAY 1996

MAY 1st

**Advances in the Management of Atrial Fibrillation**

*Robert L. Friedman, M.D., Ph.D.*

Associate Professor of Medicine

Co-Director, Cardiac Arrhythmia Service and  
Clinical Electrophysiology Laboratory,  
Cardiovascular Division, Brigham and Women's  
Hospital, Boston, MA

MAY 8th

**Advances in the Treatment of NIDDM**

*Allan J. Garber, M.D., Ph.D.*

Professor of Medicine, Biochemistry and  
Cell Biology, Baylor College of Medicine,  
Houston, TX

MAY 15th

**The Kidney as a Window to Cardiovascular  
Morbidity and Mortality**

*Leopoldo Raij, M.D.*

Professor of Medicine

University of Minnesota School of Medicine,  
Chief, Nephrology/Hypertension,  
Veterans Affairs Medical Center,  
Minneapolis, MN

### MAY 1996

MAY 22nd

**New Pharmacotherapy for Allergic Rhinitis**

*Lanny Rosenwasser, M.D.*

Professor of Medicine

University of Colorado Health Science Center,  
Head, Allergy Division, National Jewish Center for  
Immunology and Respiratory Medicine,  
Denver, CO

### MAY 1996

MAY 29th

**No Grand Rounds**

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MAY 8, 1996

**Prevention and Treatment of  
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*Allan J. Garber, M.D., Ph.D., Harry Gottlieb, M.D.*

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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# calendar

## LOOKING AHEAD

### **DIAGNOSIS AND TREATMENT OF TYPE II DIABETES MELLITUS**

**JUNE 19, 1996**

General Hospital Center at Passaic  
(AMNJ)

### **ENRICHING OUR LIVES: PROTECTION AGAINST VIOLENCE**

**JUNE 20, 1996**

Kessler Institute, West Orange  
(Kessler Institute)

### **BIOACTIVE LIPIDS IN NEURAL PLASTICITY**

**OCTOBER 28, 1996**

School of Osteopathic Med., Stratford  
(UMDNJ)

### **AMERICAN COLLEGE OF EMERGENCY PHYSICIANS**

**JUNE 19-21, 1996**

Trump Plaza Hotel, Atlantic City  
(AMNJ)

### **NJ ACADEMY OF FAMILY PHYSICIANS**

**JUNE 26-29, 1996**

Bally's Park Place Hotel, Atlantic City  
(AMNJ)

### **CLINICAL PHARMACOLOGY OF EICOSANOIDS**

**NOVEMBER 4, 1996**

School of Osteopathic Med., Stratford  
(UMDNJ)

## *Here's what we are covering in June 1996*

- ⇒ **Can New Jerseyans control tobacco use in the state?**  
Writer Bill Berlin uncovers the real story of tobacco dependency for Garden State residents.
- ⇒ **What are the new protocols for carpal tunnel syndrome?**  
Dr. Lawrence Budnick, from the Occupational Health Institute, details the current diagnosis and treatment programs for carpal tunnel syndrome.
- ⇒ **Want to know the inside scoop from Steve Adubato?**  
Read Steve Adubato's interview with MSNJ President Anthony Caggiano, Jr, MD.
- ⇒ **Should Commissioner Kessler's FDA regulations be adopted?**  
Read this provocative and hard-hitting point counterpoint from two well-known New Jersey health care professionals.
- ⇒ **What are the future plans of the New Jersey Business & Industry Association?**  
Find out the latest details from Christopher Biddle, assistant vice-president, Communications, NJBIA.
- ⇒ **Are the latest medical waste regulations working?**  
Robert Confer from the Department of Environmental Protection updates the New Jersey medical waste laws.
- ⇒ **Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.**

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## PASSING

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**THIRD:** Attend our one day **Slide Show**,  
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For further information, write to:

Medical Newsletter, 389 East Mount Pleasant Ave.,  
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201-673-4410 (day time), 201-994-3203 (evenings)

## THE SECOND ANNUAL SYMPOSIUM MEDICINE IN THE 21ST CENTURY: THE CRITICAL ROLE OF NEUROSCIENCE

MAY 15, 1996 8:00 AM-5:00 PM

SPONSORED BY  
UMDNJ-NEW JERSEY MEDICAL SCHOOL

A day-long symposium on "The Critical Role of  
Neuroscience" will be presented on Wednesday,  
May 15, 1996 at the University of Medicine and Dentistry  
of New Jersey (UMDNJ)—New Jersey Medical School,  
Newark.

Seven nationally-recognized physicians and scientists  
will discuss topics that include brain development and  
function, brain injuries and degenerative illnesses. The  
conference, the Second Annual Symposium Medicine in  
the 21st Century of the UMDNJ-New Jersey Medical  
School, will take place from 8 a.m. to 5 p.m. in the  
Medical Science Building, Lecture Hall B, 552, 185 South  
Orange Avenue, Newark.

Registration is limited and pre-registration is required.  
For more information or to register, contact the  
Department of Neurosciences at Tel: (201) 982-5208 or  
Fax: (201) 982-5059.



University of Medicine &  
Dentistry of New Jersey



BRAIN  
AWARENESS  
WEEK May 12 - 18, 1996

June 15, 1996

## 16<sup>th</sup> ANNUAL Advances in Gastroenterology Course

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**Anthony J. DiMarino, Jr., MD**

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Lecture Series  
12 noon-1 pm

Date: May 17, 1996  
Topic: "Update of Esophageal Reflux in the Elderly"  
Speaker: Charles P. Bongiorno, MD

Date: May 24, 1996  
No Lecture—Memorial Day Weekend

Date: May 31, 1996  
Topic: "Interdisciplinary Approach to Common Bile  
Duct Stones"  
Speaker: N. Kalkay, MD

Date: June 7, 1996  
Topic: To be announced

Date: June 14, 1996  
Topic: "Hormone Replacement Therapy for  
Postmenopausal Women"  
Speaker: Gloria Bachmann, MD

Date: June 21, 1996  
Topic: "Antiviral Update"  
Speaker: Spartaco Bellomo, MD

Date: June 28, 1996  
Topic: "Recent Advances in the Treatment  
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Speaker: Stephen H. Schneider, MD

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# editorial guidelines

## Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

## Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *NEW JERSEY MEDICINE* must contain the following language, and must be signed by all authors.

"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey in the event that such work is published in *NEW JERSEY MEDICINE*."

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*NEW JERSEY MEDICINE* will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *NEW JERSEY MEDICINE*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the

reviewers and the authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville NJ 08648.

## Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.





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### NEW BRUNSWICK

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### MEDICAL OFFICE SPACE OCEAN/MONMOUTH COUNTY

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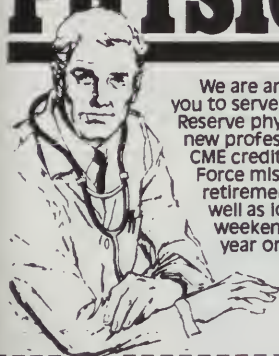
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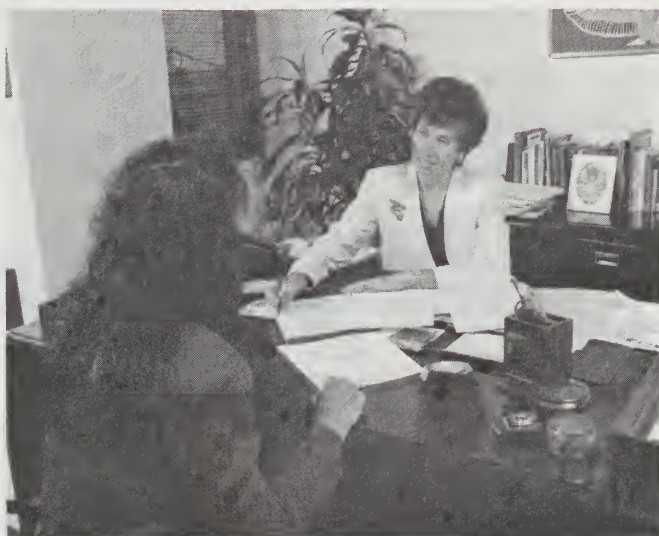
Contact Joseph A. Raimondi, M.D., FACOG, 448 Lakehurst Road, Toms River, NJ 08755. Phone (908) 244-0300.



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continued from page 72

### Alliance announces officers

The Medical Alliance to MSNJ announced its president for 1996-1997, Josie Ragasa, of Burlington County. Ragasa was inaugurated at ceremonies at the Annual Meeting in Atlantic City. The other officers are: Susan Kahn, of Monmouth County, president-elect; Valerie Claps, of Morris County, first vice-president; Gwen Jacobs, of Warren County, second vice-president; Anna Miranda, of Union County, secretary; and Rosi Bohn-Rivas, of Mercer County, treasurer. The directors are Eileen Martin Cohen, of Ocean County, Nella Lima, of Essex County, and Cosette Nascimento, of Atlantic County.

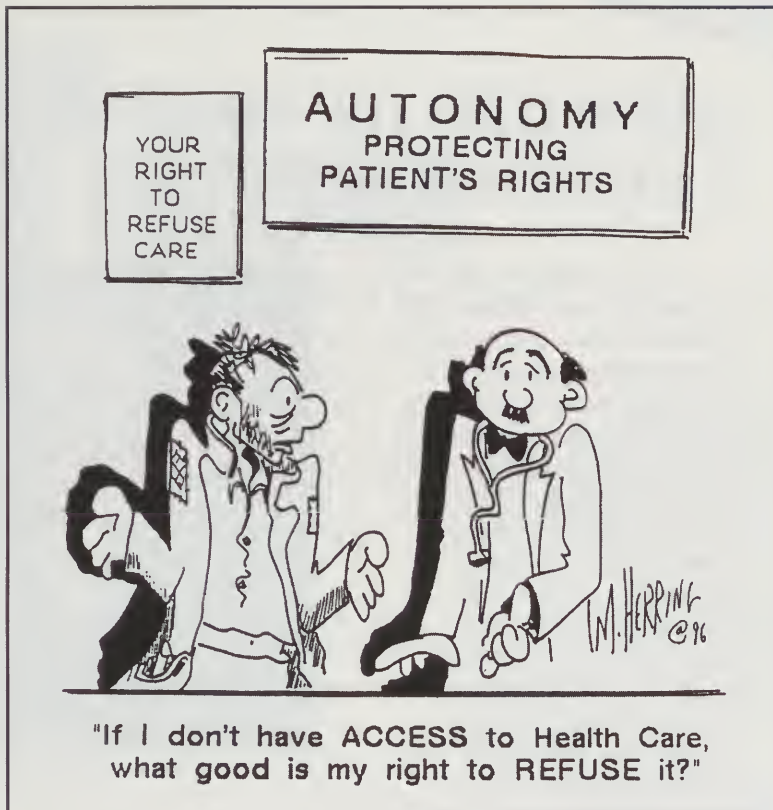
The Medical Alliance to MSNJ, founded in 1927, is an organization of physicians' spouses dedicated to the health of the New Jersey community.

### UMDNJ's allergy/asthma line

UMDNJ-New Jersey Medical School's Asthma and Allergy Research Center established a statewide telephone number for asthma and allergy information. Initiated by MSNJ member Leonard Bielory, MD, director of the Asthma and Allergy Research Center, the Center offers an intensive array of information on allergies and asthma. Health care professionals and the public are encouraged to use this information line. To access, call 1-800/NJ1-ASMA.



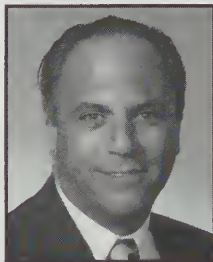
Leonard Bielory, MD



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is affiliated with Kennedy Memorial Hospital-University Medical Center, Stratford.

### Rosen named chairman

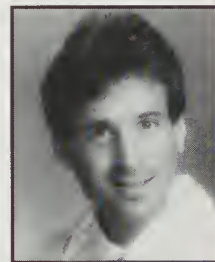
Jay S. Rosen, MD, of Upper Saddle River, has been named chair of the Medical Board of Hackensack University Medical Center. With the constant change in the health care environment, Dr. Rosen plans to reshape medical care concepts in the new managed care environment. Dr. Rosen is a member of MSNJ and of the Bergen County Medical Society and practices in Hackensack. Dr. Rosen serves as a delegate to the MSNJ House of Delegates.



Jay S. Rosen, MD

### Schwab to head NJAMSS

Richard M. Schwab, MD, of Bergen County, takes over the presidency of the New Jersey Association of Medical Specialty Societies (NJAMSS). Dr. Schwab is a member of MSNJ and of the Bergen County component. He is medical director of the Emergency Department at Holy Name Hospital, Teaneck. NJAMSS represents 22 medical specialty societies in the Garden State; the organization serves in a liaison capacity.



Richard M. Schwab, MD

**NJM**



## ADVOCATING FOR IMPROVING AND FACILITATING QUALITY OF CARE

The Medical Review and Accreditation Council (MRAC) is an independent corporation dedicated to improving and facilitating quality of care rendered by physicians. Established in 1995 by MSNJ, MRAC activities involve streamlining and centralizing the verification of physicians' credentials and reviewing physicians' records and offices. MRAC leaders believe that a physician should not have to be reviewed and inspected separately, at substantial expense, by every plan or group to which the physician belongs or has applied. When quality of care is promoted, physicians and patients benefit. For more information, call MSNJ, 609/896-1766.

### Honoring health professionals

The AMA honors physicians and other health professionals throughout the year. Nominations for the Distinguished Service Award, Citation for Distinguished Service, Scientific Achievement Award, Dr. Benjamin Rush Award, AMA-ERF Award for Health Education, and President's Citation for Service to the Public are due by September 6, 1996. A curriculum vitae and letter of nomination should be sent to Joseph A. Riggs, MD, MSNJ, Two Princess Road, Lawrenceville NJ 08648.



*Louis L. Keeler, MD, MSNJ immediate past-president, and Anthony P. Caggiano, Jr, MD, MSNJ president*

### New faces at MSNJ

MSNJ announces its new president, Anthony P. Caggiano, Jr, MD, of Essex County. Dr. Caggiano, the 205th president of MSNJ, is an obstetrician/gynecologist with a practice in Glen Ridge. Dr. Caggiano is affiliated with Clara Maass Medical Center, Belleville, The Mountainside Hospital, Montclair, and Saint Barnabas Medical Center, Livingston. He was inaugurated earlier this month at the MSNJ Annual Meeting in Atlantic City. Other officers are: Carl Restivo, Jr, MD, of Hudson County, president-elect; R. Gregory Sachs, MD, of Union County, first vice-president; Irving P. Ratner, MD, of Burlington County, second vice-president; George J. Hill, MD, of Essex County, secretary; and Eileen M. Moynihan, MD, of Camden County, treasurer. Louis L. Keeler, MD, of Camden County is the immediate past-president.

### Endorsed programs available to MSNJ members

MSNJ has combined its endorsed services program with the Medical Inter-Insurance Exchange (MIIX) financial services division to provide New Jersey physicians with a new, single source of expert information on products they buy or use in their practice of medicine. These endorsed services will help physicians address the business side of medicine and improve the way physicians manage the business side of their practice. For more information on the variety of programs offered—from medical waste services to magazine subscriptions—call 1-800/227-MIIX.

*continued to page*

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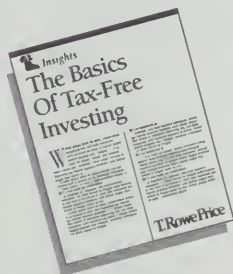


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\*Some income may be subject to the federal alternative minimum tax. Income earned by non-New Jersey residents will be subject to applicable state and local taxes.

†Morningstar proprietary ratings reflect historical risk-adjusted performance as of 3/31/96. These ratings, which may change monthly, are calculated from the fund's 3-year annual returns excess of 90-day Treasury bill returns with appropriate fee adjustments and a risk factor that reflects fund performance below 90-day Treasury bill returns. Ten percent of funds in an investment category receive 5 stars and the next 22.5% receive 4. The fund's 3-year rating was 4 stars.

†\$500 minimum.

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06/21/96

# NEW JERSEY MEDICINE

*Health Care in the Garden State*

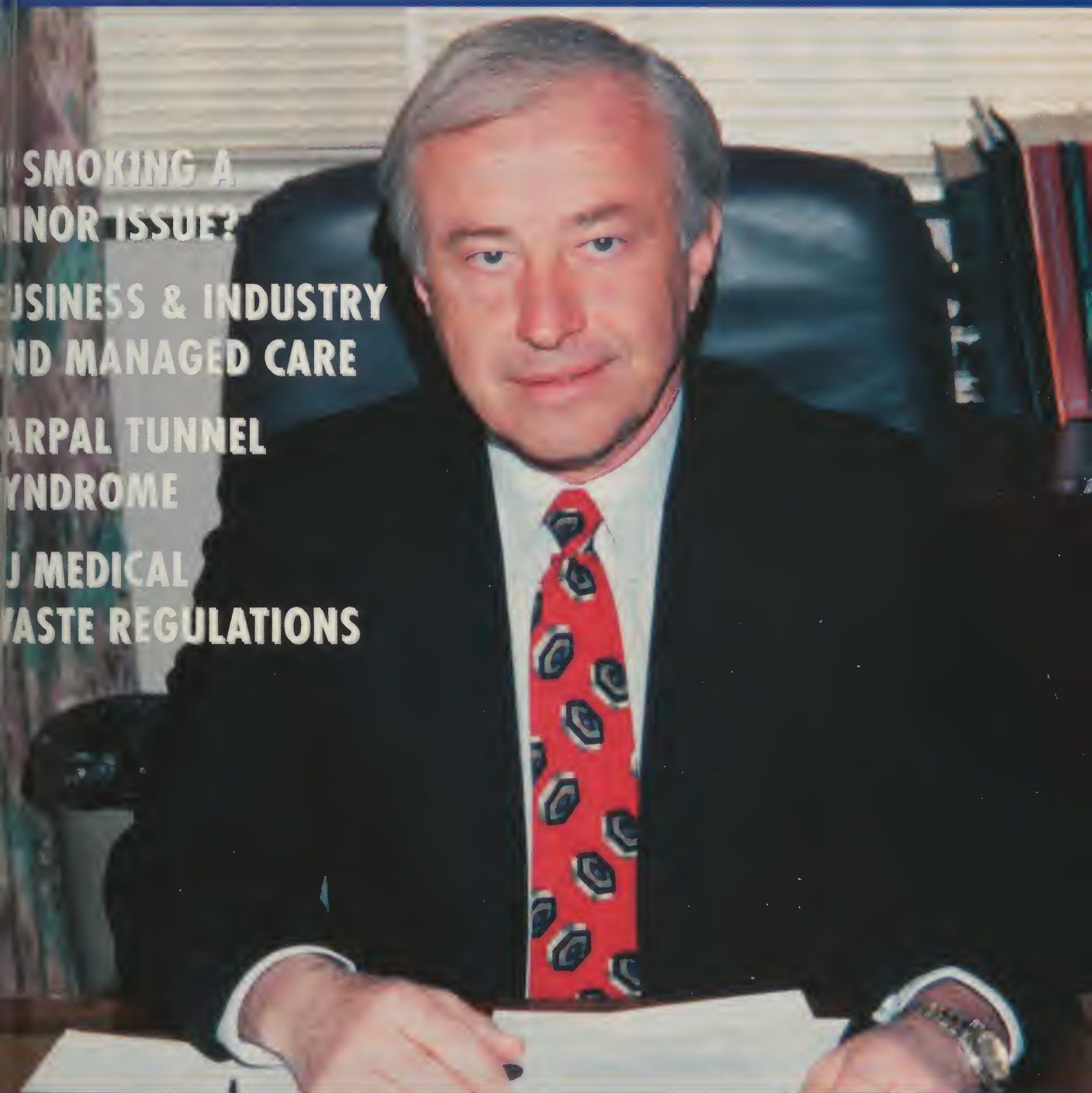
*June 1996*

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Life expectancy at birth has increased, and infant mortality has fallen, reports the state Department of Health (DOH) in a 1996 update of "Healthy New Jersey 2000: A Public Health Agenda for the 1990s." But, the 124-page report offers no signs of improvement in the percentage of pregnant women who receive prenatal care during the first trimester, and no decline in teenage birth rates.

From 1988 to 1992, the statewide **infant mortality** rate declined an impressive 15 percent, to 8.4 infant deaths per 1,000 live births. In this indicator, New Jersey is substantially ahead of the nation as a whole and, according to DOH, may achieve the goal of a 7.0 rate by the new millennium. The rate for blacks, though, remains more than twice as high as the total rate.

During the time period from 1991-1993, says the report, the overall **life expectancy** rate for whites rose more than one year to 77.0, while the corresponding rate for minorities rose more than one-half year to 71.4. These figures are roughly commensurate with national averages.

New Jersey lags, fairly abysmally, in first-trimester **prenatal care**. This indicator declined to less than 73 percent in 1992, or 5 percent less than the national average. But, happily, our overall **teen birth** rate is still about one-third lower than that of the whole country.

Reputation among late-night television comedians notwithstanding, New Jersey generally scores reasonably well on public health indicators, or at least no worse than do most other states. For example, across a spectrum of ten indicators of

"child well-being," the Annie E. Casey Foundation gave New Jersey a composite rank of 21 among the 50 states.

**New occupational employment projections compiled by the state Department of Labor (DOL) include big increases for most health care occupations. Indeed, nursing aides and orderlies rank just behind systems analysts as the fastest growing groups, with almost 29,000 new jobs forecast for these two health occupations between 1994 and 2005.**

The estimated growth rate for **physician** "jobs" was a modest 3.1 percent, but even this figure will surprise criers of doom in the profession. Similarly, for **nurses**, the figure was a virtually whopping 14.4 percent. In strictly percentage terms, however, no other handle can hold a candle to **physician assistants** (PAs), whose projected growth rate is just a shade under 298 percent, presumably as a result of recent liberalizations in legislative and regulatory constraints on PA practice.

More broadly: To rationalize health workforce policy, the Association of Academic Health Centers (AHC) has called for creation of a new "national policy board that represents all the competing interests." The recommendation appears in a just released, lengthy report entitled, "The U.S. Health Workforce: Power, Politics, and Policy."

Writers of the AHC report admonish: "Uniform national standards and role definitions for health professionals are needed to promote consistent quality of care, more efficient use of national resources, and more equality among the professions, and to depoliticize the professional entanglements at the state level." Not in New Jersey, surely.



**In case the reader can absorb even more data, interesting numbers were found in the latest annual report of U.S. Healthcare, prepared prior to the announcement of a planned merger with Aetna Life & Casualty Co. Total assets for the 2.4 million member HMO were listed at \$1.67 billion, and shareholders' equity (assets less liabilities) at \$964 million.**

It's remarkable that, in health care, a business that is so comparatively small can be so strong and powerful. As of this writing, the merger is under investigation by the Federal Trade Commission.

Mergers also were highlighted, literally, in a compilation of certificate-of-need (CN) data issued by DOH. Combined operating revenue for the Liberty Healthcare System was \$245 million in 1994; this Jersey City Medical Center-Meadowlands Hospital Medical Center conglomerate is expected to be a staging platform for the Columbia HCA system that is planning a major incursion into the Garden State.

The CN folks also released a summary of applications received for assisted living. DOH efforts to promote this less intensive, lower-cost alternative to nursing home care have generated 107 announced CN applications, with bed complements ranging from 26 to 200.

**While shifting its mission from author to reviewer of clinical guidelines, the federal Agency for Health Care Policy and Research (AHCPR) has launched a new software product intended to provide easy access to 1,200 measures of clinical performance.**

What AHCPR termed a "landmark computer tool" will enable health care payers and providers, as well as other

researchers, to measure individual or local performance against established benchmarks. The package is named **CONQUEST 1.0**, for "Computerized Needs-oriented Quality Measurement Evaluation System."

As with clinical performance indicators, quality and cost concerns intersect in a new development that *Healthcare Leadership Review* says is becoming increasingly prevalent among providers: implementation of **demand management** programs.

Demand management is based on the idea that demand for health services emanates from morbidity and from perceptions of need, from patients' preferences and responses to medical advice and information, and from non-health concerns. To restrain unnecessary demand, providers may use telephone support to screen appointment requests, self-help materials, and health education and health promotion strategies.

**New Jersey has joined 11 other states in prohibiting health and life insurers from denying benefits to victims of domestic violence. But, what the other states did by legislation, the Garden State did by regulation that carries the signature of Insurance Commissioner Elizabeth Randall.**

Domestic violence coverage has gained the attention of senators and congressmen. Insurers have admitted using domestic violence as a pre-existing condition. *State Health Notes* suggests that insurers continue to object to paying claims for treating a condition caused by violence, unless the insurer also has to pay for the same condition when caused by factors other than violence. Of arms and women we sing.

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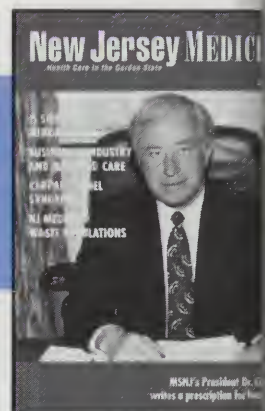
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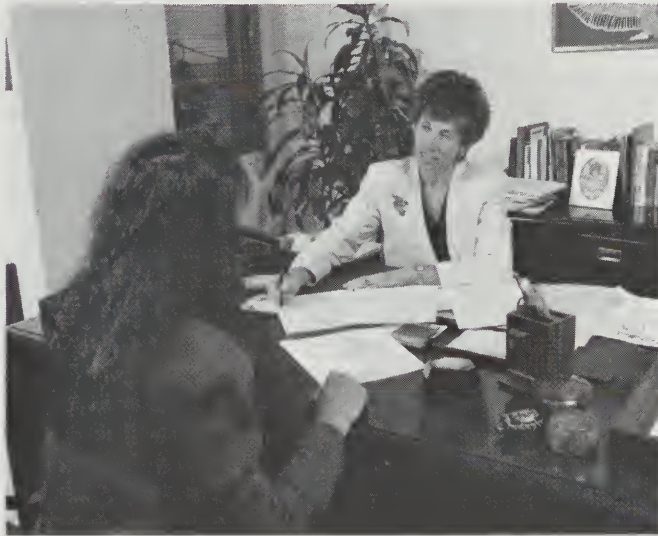


The spotlight is on Anthony P. Caggiano, MD, MSNJ's president from 1996-1997. Dr. Caggiano highlights MSNJ's role in today's changing health care environment. *Cover © Double Exposure*

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# New Jersey MEDICINE

*The following letter was sent to Congressman Saxton concerning Hyde/Archer (HR 2925):*

On behalf of the 9,500 physician members of MSNJ, I ask you to take a closer look at a trend that threatens the integrity of our health care system.

The recent purchase of U.S. Healthcare by Aetna Insurance Company will create a megacompany that will insure 1 of every 12 persons in the United States currently enrolled in a managed care plan. In New Jersey, the Aetna/U.S. Healthcare megacompany will cover a full 43 percent of all managed care patients.

In most industries, this narrowing of the competitive playing field would spark concerns about antitrust activities. Because of the McCarran-Ferguson Act, antitrust restrictions do not apply in the insurance industry. The medical profession stands to be run over, as more mergers of insurance companies produce large conglomerates and reduce competition. The result will be a great loss in patients' choice of health plans and physicians—a loss that will prove intolerable to many people and jeopardize the quality of care.

Organized medicine needs your help in leveling the playing field. The physicians of New Jersey ask you to favorably consider the Hyde/Archer Bill (HR 2925), which will enhance physicians' ability to form managed care networks. These networks would enhance competition, and serve as a brake on unresponsive insurance practices. The bill was marked up in March, with official reports expected in the upcoming weeks.

Although managed care companies have brought several positive aspects to health care delivery, they fail to contribute to uninsured care or assist the medical education system in New Jersey. Operating under the guise of cost controls, these insurance companies implement policies and procedures that serve to produce "managed profit" of

up to 15 percent of the premium dollar, rather than managed care.

As managed care companies have grown, they've exerted greater influence on what physicians think, do, and say. In many patients' minds, this influence is creating questions whether physicians may have to compromise opinions under fear of being deselected or reprimanded by an insurance company.

A physician's objective is to provide affordable, quality health care according to the principles of our profession. With the absence of antitrust controls governing the insurance industry, HR 2925 may very well represent our best hope in carrying out our objective.

*Louis L. Keeler, MD  
Immediate Past-President, MSNJ*

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To submit a letter, FAX (609/896-1368) or mail a copy of your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

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## Joseph L. DeStefano, MD

Joseph L. DeStefano, MD, has been named medical director of obstetrics and gynecological services for AtlantiCare Health System. Dr. DeStefano will continue to serve as chair and chief attending for the Department of Obstetrics and Gynecology at Atlantic City Medical Center.

## New Jersey Breathes Coalition sponsors youth in session at the Legislature

Tenth graders from around the Garden State met at the state's capitol for a first-hand interaction with the political process during "Youth in Session," sponsored by New Jersey Breathes Coalition, the American Cancer Society, New Jersey Division, Inc., and Consumers for Civil Justice. The focus of the event was tobacco within a mock vote on a bill

raising the state excise tax charged on cigarettes. Speakers included Governor Christie Whitman and Commissioner Len Fishman. Students from 24 legislative districts modeled their legislators during a vote on increasing tobacco taxes. The vote: 61-4 in favor of

increasing the tax. New Jersey Breathes Coalition is a multi-agency tobacco control project covered by MSNJ.

## Assistance for Medicare enrollees

Counseling on Health Insurance for Medicare Enrollees (CHIME) offers one-on-one, free, confidential assistance and information to New Jersey Medicare beneficiaries who have problems with or questions about their health insurance. This statewide program is administered by the New Jersey State Departments of Community Affairs and of Insurance with funding from the U.S. Department of Health and Human Service's Health Care Financing Administration. Counselors are available in all 21 counties of the Garden State. Call toll-free at 1/800/924-7108 for information.



## Sister Patricia Lynch

The Bergen Pines County Hospital Foundation, Inc. presented Sister Patricia Lynch, president and CEO of Holy Name Hospital, in Teaneck, the Distinguished Community Health Service Award for her outstanding work with the hospital's women's health services.



(Left to right) Michelle Evans, Jared Carey, Louis Keeler, MD, and Akisha Jones.

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## Preventing medication errors

The nonprofit Institute for Safe Medication Practices (ISMP) now produces a biweekly FAX newsletter containing the most up-to-date and accurate information available about medication, device errors, and preventable adverse drug reactions. *ISMP Medication Safety Alert* offers timely information to health care professionals. "One of the best things we can do to prevent errors," says ISMP founder Michael R. Cohen "is to share the information we have as soon as possible." Inquiries can be directed to ISMP, 320 West Street Road, Warminster, Pennsylvania 18974.

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# Dancing with the devil: Fighting the tobacco war in New Jersey

The war against tobacco products and its purveyors has reached a critical juncture. The sale of cigarettes in the United States has decreased and there are fewer adult smokers. But the percentage of teenage and younger smokers has not declined, and the overseas sale of American-made cigarettes continues to produce record profits for Philip Morris and others.

Richard Kluger, author of *Ashes to Ashes: America's Hundred-Year Cigarette War, the Public Health and the Unabashed Triumph of Philip Morris*, has written a provocative article in *The New York Times Magazine*, of April 7, 1996, entitled "A Peace Plan for the Cigarette Wars," with headings inscribed "Dance With the Devil." He hopes to save some of the more than 400,000 lives lost to smoking annually in this country by making a deal—to dance with the devil. He asks us to reconsider the half-truths propagated by crusaders and reporters.

Kluger lists three half-truths and suggests five ways to settle some of the legal battles and to decrease the use of tobacco products.

1. He says the economic costs that smokers inflict on society to treat associated illnesses is not as large as commonly expressed, mainly because smokers die at earlier ages and

miss the tax-supported benefits of Social Security and Medicare, and the accrued values of pension plans and similar benefits.

2. He implies that deliberate controlling of the levels of nicotine or other ingredients in cigarettes should not surprise us; this is the proper way for companies to insure uni-

form quality. And they have tried to decrease the toxicity of the product with filters and other innovations.

3. He opines that the manufacturers have not conspired to suppress their findings relating to health hazards because these hazards were generally well-known for many years. He agrees, however, that the companies failed to publish meaningful research because the results would constitute severe indictments of the products, and they resisted and disparaged the evidence that others had collected and disseminated.

I disagree somewhat with Kluger. Although the tax burden may be decreased by the shortened longevity of smokers, he omits the economic losses associated with absenteeism, produced by illness and by the time taken away from work to enjoy the nicotine high. As Colette wrote in *The Pure and the Impure* in 1933, "Smokers, male and female, inject and



Howard D. Slobodien, MD

*We should deter  
the use of  
tobacco  
products,  
punish the  
tobacco  
companies, and  
compensate the  
injured.*



excuse idleness in their lives every time they light a cigarette." Also, it is certainly true that uniform quality is a hallmark of good manufacturing technique, but that is not an issue. Whether the companies lied, for commercial gain, is the issue. And Kluger concedes that the tobacco manufacturers knew of the adverse effects of tobacco on the human body for many, many years.

The author's suggestions for change are interesting and provocative:

- The tobacco companies would be granted legislative immunity against pending and future suits, producing financial stability in an important segment of our economy. The justification: the public should have known of the health hazards and should have assumed its own risks.
- The FDA would be granted extensive regulatory powers over the manufacturing and packaging of cigarettes.
- Health warnings on packages would be increased and enlarged.
- OSHA regulations regarding smoking in the workplace, and FDA programs to decrease the attraction of smoking to the young, would be implemented.
- The federal cigarette tax would be doubled, and an additional levy would be imposed to fund an augmented anti-smoking campaign.

My own suggestions have two purposes: primarily, to deter the use of tobacco products; secondarily, to punish the miscreants who have enslaved so many millions, and to compensate some of the injured. If you feel that there is justification for the secondary goal, Kluger's recommendation about forgiving the tobacco companies is off base.

With a calculated omission of FDA regulation, a subject covered elsewhere in this issue, let me give you some of my suggestions:

- Restrict all advertising, direct and indirect, and minimize the amount of space allowed on packages for identification of the contents. Out of sight, out of mind.
- Remove—do not increase—the warning labels on cigarette and other tobacco products to increase the manufacturers' (and distributors'?) liabilities for adverse effects not carefully identified.
- Increase the tax on these products. Have the New Jersey Legislature reconsider its previous failure. Use the money for education and treatment.
- Increase the development of alternate uses of tobacco, while retraining those involved in its production and manufacture.
- Scale back and eliminate the federal trade agreements that create bonanzas for American tobacco companies abroad.
- Support the AMA policy that recommends divestiture of investments that include equities of the tobacco establishment.

"Tobacco, divine, rare, superexcellent tobacco, which goes far beyond all the panaceas, potable gold, and philosophers' stones, a sovereign remedy for all diseases" wrote Robert Burton in *Anatomy of Melancholy* in 1621. But then he continued, "As it is commonly abused by most men, which take it as tinkers do ale, 'tis a plague, a mischief, a violent purger of goods, lands, health; hellish, devilish, and damned tobacco, the ruin and overthrow of body and soul." Today's society tends to recant in similar fashion. Can this renunciation be translated into meaningful action? How do we get our children to recognize pernicious peer and commercial pressures?

Your comments and criticisms are welcomed and encouraged.

**NJM**

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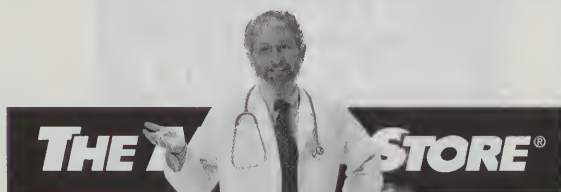
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## INTERVIEW WITH ANTHONY P. CAGGIANO, JR, MD

**Q.** What's your vision for MSNJ? How do you see your tenure as the 204th president?

**A.** The main thing is to try to help our members at a time when there is tremendous turmoil in the profession. There's a lot of confusion, coercion, and change. Right now, the cottage industry is going into a corporate entity, and we're concerned. In New Jersey, a state with over 7 million people, there's only one multidisciplinary medical group. Everything is small solo practices, partnerships, or single-discipline groups.

**Q.** Do you think the average physician in this state is ready for this corporatized, bureaucratic new world?

**A.** If you were sitting in my spot, would you be ready for

this? I think it's the job of MSNJ and organized medicine to assist their members to get ready for what looks inevitable. Now, it probably will not be as bad in the future as it is now, with gag clauses and all the other restrictions. We probably will swing back to a more moderate level, with input from the physicians. My question is, "Are the patients ready?" We're hearing their complaints now.

**Q.** What are you hearing?

**A.** We're hearing that they don't have the choice of physicians, that they're not able to see the doctor, and that when they do see the physician, it's very quick and they don't get their questions answered. The quality is just not there. If you have to see six or eight

patients in an hour, you're not going to be able to provide the quality care you did in the past.

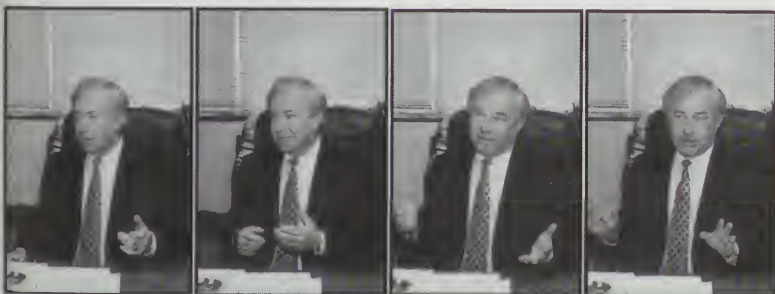
**Q.** Specifically, how can MSNJ help physicians deal with this changing environment?

**A.** One thing is that any contract a physician signs with an HMO, MSNJ will review by our attorneys at no charge. If there are de-selection clauses or gag clauses, we will point them out. Some doctors have signed anything that came across their desk because they were worried about losing a portion of their practice.

We also have seminars and conferences to educate physicians before they are confronted with these decisions, to let them know what managed care is all about.

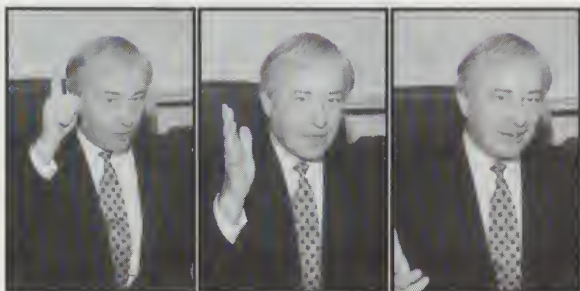
**Q.** Is the alternative an organization such as Physician Healthcare Plan of New Jersey, where doctors seem to be more involved and have an ownership stake?

**A.** Absolutely. We have to encourage our physicians to be



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involved in organizations and provider networks where they can have some decision-making clout as far as utilization and the direction in which managed care is going. Right now, entities like U.S. Healthcare and CIGNA will say that doctors are involved, but the doctors are paid by the companies, so they do what the companies tell them to do.

Can we compete with the big boys? I don't know. But we certainly have to get some anti-trust relief and be allowed to compete on an even playing field. Right now the field is too uneven. One of the ways to do this is through having input into the HMO regulations, which we've tried to do.

Commissioner Len Fishman has been quite responsive and certainly has given MSNJ a place at the table. They are not going to give us everything we want, but at least they will hear us and consider our options.

to do this. Others say that physicians are so used to being independent that this approach won't work. What do you say to this?

**A.** First of all, physicians will hire professional experts to help them set up and run these organizations, just like we did when we created our own insurance company. With physician-owned health care, physicians would be constant participants in terms of the board, utilization review, and medical guidelines. That's not the case with the standard HMOs today.

Financially, this would be better for all concerned. You're eliminating the insurance company and the third-party administrator, and saving a portion of the health care dollar to make your premiums lower and your quality better. The problem is that the insurance companies have deep pockets, and the physician groups do

**Q.** Some people say that it's a good idea, but the physicians don't have the business skills

not. That's what happened to the physician group in Connecticut. They got so far and then they sold out to an HMO.

**Q.** You've also said that physicians need to be patient advocates. What do you mean? Should a physician talk with a patient about the scope of care?

**A.** Absolutely. I take extra time, and I know many colleagues take extra time to explain things to patients. What is happening to the patient is that each year the employer has switched health coverage, because it is looking for the best deal. The result is that many people are very confused.

The employer might say that the employee can pick the more expensive plan, the fee-for-service plan. But many of these employees are young people with families who cannot afford to go out-of-network. So, therefore, in a very subtle way the patient is being abused, just like the new mothers were being abused who were sent home from the hospital 24 hours after giving birth.

*In his inaugural address at the MSNJ Annual Meeting, Dr. Caggiano outlined ten points for an optimistic future:*

**"They'll never care how much you know until they know how much you care."**

1. Physicians should be patient advocates.
2. I favor three forms of choice: patients should have their choice of physician; physicians should have choice of whom they serve; and patients, with their physicians, should choose a proper course of therapy.
3. We want patients to receive quality care and prompt, appropriate medical-surgical services. Physicians need the freedom to practice medicine without undue bureaucratic or unwarranted economic barriers.
4. Managed care organizations say they want quality care; quality care comes from well-trained physicians and yet not one company has donated to medical education.
5. We tried to protect mothers and newborns. While HMOs were kicking women and newborns out of the hospital in 12 to 24 hours after childbirth and denying emergency room visits, they were willing to pay tens of thousands of dollars for carpeted lockers in corporate gyms for their administrators.
6. We urged DOH to act in an oversight capacity and thanks to Commissioner Len Fishman, DOH recently drafted HMO regulations with input from MSNJ.
7. I am pleased to see the rapid growth of physician-owned and direct-ed managed care plans such as the Physician Healthcare Plan of New Jersey. These plans can successfully compete under capitation, permitting physicians to practice quality care medicine at lower costs.
8. I have high hopes that we can deal effectively with government and threatening corporate structures. MSNJ is working to assist our physician members. MSNJ must persuade physicians to become more politically active and fight for choice, tort reforms, anti-trust relief, and the right for physicians to practice quality medicine unencumbered.
9. We must be united before we can stand firm. We need trust and self-restraint to maintain the respect of the public. If we don't collectively fight for our patients' health care rights and quality care, who will?
10. I pledge to continue to form friendly alliances to achieve many goals from state health reform measures to successful tort reform.

**Q.** Does being a patient advocate mean working more closely with unions and other consumer coalitions?

**A.** Definitely. For example, we have worked with the senior citizens in Essex County to explain to them the advantages and disadvantages of mandatory Medicare assignments.

**Q.** You've been involved with MSNJ for more than 20 years. What do you see as the basic role of this organization?

**A.** Some physicians occasionally approach me and say, "What is MSNJ doing for me?" I tell them that there are 35 or 40 things, including HMO contract review, regulatory oversight, and countless legislative efforts that have saved them money regarding EPA regulatory fees or mandatory Medicare assignments, to name just two areas. We monitor the state Board of Medical Examiners, the Department of Health, and the Department of Insurance. We try to protect physicians and patients from detrimental policies, like the one that was sending mothers home from the hospital 24 hours after giving birth. This is a record for which we all can feel good.



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# The minor side of smoking

*Bill Berlin, PhD*

Richie T. is a teenager from an affluent family in Westfield, where he attends the local high school. His grades are good and he expects to go to a major out-of-state university next year. Richie hangs out with different cliques, drinks occasionally at weekend parties, and likes a girl who does not seem to notice him. Richie started smoking Marlboros last year. He likes the taste of tobacco and says that his friends who smoke are "cool" and "interesting." He sees a lot of adults who smoke, and he is certain he could quit whenever he feels like it. Richie does not think about the health effects of smoking, and apparently he is not alone.

As the health case against tobacco continues to mount, anti-smoking forces are struggling with a vexing dilemma: How to reduce the rising numbers of young smokers like Richie.

This is no "minor" issue. One recent study estimated that teenagers who take up smoking

smoking as a "pediatric disease," and the condition seems to be spreading. In 1991, 28 percent of high school seniors reported smoking during the previous 30 days, but by 1993 that figure had risen to 30 percent. Between 1991 and 1994, the percentage of eighth graders who smoke jumped by 30 percent, with a corresponding increase among tenth graders of 22 percent. In some states, the rate of smoking among young people is as high as 40 percent, 15 percent higher than the national average for adults.

These statistics portend another disturbing trend. Cigarette consumption, which had declined annually by 2

to 3 percent in the 1980s, now has leveled off, a fact attributed to a sharp rise in smoking among young adults and underage smokers. In other parts of the world, most notably Asia, cigarette sales have substantially increased.

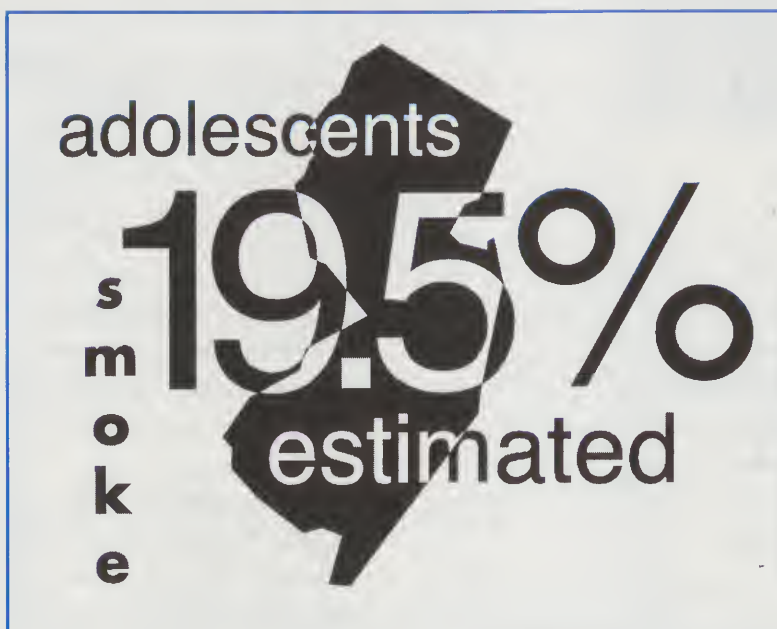
The tobacco companies take the youth market seriously, as a new source of smokers to replace



today will stay addicted for an average of 16 to 20 years. More than 80 percent of smokers start by age 18, with the average teenage smoker beginning at 14.5 years of age. Among daily adult smokers, 89 percent began using cigarettes and 71 percent began smoking daily by age 18.

The Food and Drug Administration (FDA) has described





the 3,000 people every day who either die from or quit smoking. Internal documents suggest that, despite company denials, young people have long been a target of cigarette advertising and marketing campaigns. The tobacco industry spends \$18 million a day in cigarette advertising here and abroad, much of which effectively appeals to young people. A study released in April 1996 found that sensitivity to cigarette advertising is almost three times higher among teenagers than among adults.

Recently, the companies have introduced new brands, such as Red Kamel, Dave, and Moonlight Tobacco, that feature "hip" advertising campaigns aimed at young adults. Even Joe Camel, forced into exile by critics as a market ploy aimed at children and teens, has returned from the desert to promote smoking to the 18-to-30-year-old crowd. Giveaways, promotions, and ads in such outlets as *Rolling Stone* and *Details* aim at both young adults and underage smokers who look up to them.

Given this marketing offensive, what are anti-smoking forces doing to deal with these messages? On the federal level, the FDA is considering a series of measures aimed at reducing access to children, including requirements for age verification and face-

to-face sales and the elimination of mail order sales, vending machines, self-service displays, and free samples. The FDA also has proposed prohibitions on advertising, promotions and giveaways, and brand-name sponsorship of sporting and entertainment events.

In New Jersey, where an estimated 19.5 percent of adolescents smoke, both state and local governments have stepped up efforts to limit youth access to tobacco. A state law enacted earlier this year authorizes that revenue derived from an increase in the retail tobacco licensing fee be used to increase

enforcement of age-of-sale statutes preventing sales to minors. Bonnie Schuster, responsible for implementing this legislation for DOH, expects 17,000 statewide random site inspections during 1996-1997, in accordance with state and federal mandates.

On the local level, East Brunswick was the first community to ban cigarette vending machines in 1991. Since then, more than 100 other localities have enacted ordinances controlling tobacco sales, through total bans or restrictions on vending machines, self-service bans on cigarettes and other tobacco products, and related measures. More than 50 communities across the state have imposed limited controls on smoking, primarily through a total ban on lighting up in government buildings. Under the leadership of Mayor Dr. Austin Kutscher, a cardiologist, Flemington is the only town in the state that actually prohibits teenage smoking.

One area where more might be done is education. "When it comes to tobacco, the companies are the biggest health educators," says John Slade, MD, associate professor of clinical medicine at UMDNJ-Robert Wood Johnson Medical School in New Brunswick. Tobacco advertising depicts smoking as desirable adult behavior, associated with attractive,

lively, and healthy people. Billboards and print advertisements seductively appeal to adolescents' wish for power, control, and individuality. In many movies aimed at young people, smoking has a supporting role.

Unfortunately, most school systems do not go beyond the few half-hours mandated for tobacco education in the course of a student's career. Some school systems, such as West Essex, have developed more serious prevention policies that are being disseminated throughout the state. Taking a somewhat different educational route, MSNJ sponsors a community grant program, implemented through New Jersey Breathes, which awards \$8,000 to \$10,000 each year to innovative local efforts, such as peer-to-peer and police outreach programs. New Jersey Breathes, an independent collective voice for tobacco control convened by MSNJ, is a coalition of eight agencies promoting a tobacco-free state. Its goals are to eliminate smoking in public places, prohibit the tobacco industry's access to youth, and reduce the use of tobacco by pregnant women and minority populations.

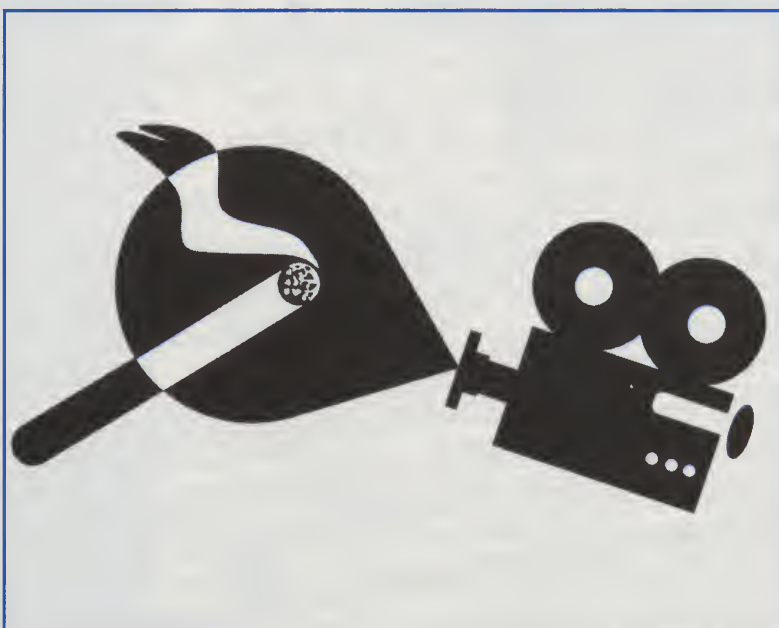
Dr. Slade also notes that there are other ways in which schools can combat the appeal of smoking. One way in which schools can show that there is no safe way to use tobacco is through example. Schools, he argues, should be completely tobacco-free, prohibiting smoking by teachers, staff, and students anywhere on school grounds.

Another possible weapon is an increase in the cigarette tax. Health economists often cite a direct relationship between price increases and a decline in youth smoking. Raising the price of a pack of cigarettes might offset the higher levels of disposable income available to

youth in New Jersey, a relatively wealthy state. In a few states, such as California and Massachusetts, higher cigarette taxes have helped fund counter-advertising that has been instrumental in reducing smoking among youth and adults.

To some anti-smoking activists, these efforts to curb youth smoking, however admirable, fall short of the mark. Laws limiting access are but "a small part of the solution," says Regina Carlson, executive director of the New Jersey Group Against Smoking Pollution (GASP), because young people can always find ways to obtain cigarettes. A better approach, she contends, involves a wider pro-health campaign to counter smoking at all levels, among adults and adolescents. "The real problem," says Ms. Carlson, "is not supply, but demand."

In fact, the tobacco industry's recent "We don't want kids to smoke" advertising campaign has some public health experts thinking that appeals to young people may even be misplaced. Most youngsters who take up smoking see it as an adult behavior they want to emulate, a way of shedding the image of being a kid. As Dr. Stanton Glantz points out in a recent editorial in the *American Journal of Public Health*, an emphasis on underage smoking allows the





tobacco industry to appear reasonable while reinforcing the appeal of smoking as an attractive adult behavior.

Dr. Glantz believes that the emphasis should be shifted away from supply controls and law enforcement, especially efforts to criminalize children for possession or use of tobacco. The real emphasis should be on increasing taxes on the tobacco industry for sales to children, increased pro-health, anti-smoking education campaigns, and a general reduction of tobacco consumption throughout society. While he generally applauds the FDA's proposed regulations on tobacco, he believes the agency should de-emphasize law enforcement steps "directed at keeping kids from buying tobacco and focus on keeping kids from *wanting* tobacco."

What about the health care profession? Several national surveys found that only about one-half of current smokers report having ever been asked about their smoking or advised to quit. A 1995 UMDNJ-Eagleton Poll found that most patients surveyed in New Jersey do not believe that physicians were sufficiently interested in anti-smoking efforts. Of those smokers whose physicians knew that they smoke, only 42 percent said that their doctors offered to help them quit.

If this picture is accurate—and some medical organizations dispute it—the problem may lie in historic patterns of professional and societal neglect. Medical education has generally ignored smoking prevention and cessation, insurance companies have typically refused to cover nicotine addiction programs, and most managed care organizations, which tout preventive health, have shied away from intervention programs.

The situation seems to be changing, as the health care profession has become more involved in anti-smoking efforts on almost every level. Hopefully, as the new clinical practice guidelines suggest (see sidebar), when it comes to nicotine addiction, the medical profession is not just "blowing smoke."

**NJM**

#### NEW CLINICAL PRACTICE GUIDELINES

An independent panel of scientists, clinicians, consumers, and methodologists, selected by the U.S. Agency for Health Care Policy and Research, recently issued *Smoking Cessation Clinical Guidelines* for three groups of professionals: primary care physicians, smoking cessation specialists, and health care administrators, insurers, and purchasers.

In regard to smoking and its related diseases, the panel stated that "it is difficult to identify a condition in the United States that presents such a mix of lethality, prevalence, and neglect, and for which effective interventions are so readily available."

For primary care physicians, the panel recommended the following steps:

**1. Ask—Systematically Identify All Tobacco Users at Every Visit.**

Implement an officewide system that ensures that for every patient at every clinic visit, tobacco use status is queried and documented.

**2. Advise—Strongly Urge All Smokers To Quit.**

In a clear, strong, and personalized manner, urge every smoker to quit.

**3. Identify Smokers Willing To Make a Quit Attempt.**

Ask every smoker if he or she is willing to make a quit attempt at this time.

**4. Assist—Aid the Patient in Quitting.**

- A. Help the patient with a quit plan.
- B. Encourage nicotine replacement therapy except in special circumstances.
- C. Give key advice on successful quitting.
- D. Provide supplementary materials.

**5. Arrange—Schedule Followup Contact.**

Schedule followup contact, either in person or via telephone.

(The complete version of the panel's recommendations is available in *JAMA*, April 24, 1996, Vol. 275, No. 16.)

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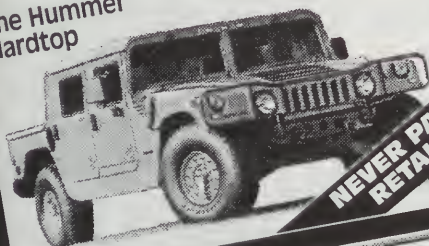
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# CLINICAL STRATEGIES FOR WORK-RELATED CARPAL TUNNEL SYNDROME

Lawrence D. Budnick, MD, MPH

**Dr. Budnick is affiliated with the Department of Medicine, Occupational Medicine Service, UMDNJ-New Jersey Medical School, Newark.**

Carpal tunnel syndrome (CTS) is a multifactorial potentially disabling condition associated with dysfunction of the median nerve and the tendons in the wrist carpal tunnel. CTS is characterized by sensory symptoms in the distribution of the median nerve, with increasing motor symptoms as the condition progresses. Up to 47 percent of all cases of CTS may be work-related and associated with repetitive, forceful grasping or pinching, awkward positions of the hand and wrist, direct pressure over the carpal tunnel, and the use of vibrating hand-held tools.<sup>1,6</sup> Over 330,000 cases (64 percent) of work-related illnesses in the United States are associated with repetitive trauma. Others, however, dispute the association between work and CTS.<sup>7</sup> Nonoccupational risk factors include congenital defects, wrist size, oral contraceptives, pregnancy, obesity, diabetes mellitus, gout, and other systemic diseases.<sup>3-10</sup>

The American Medical Association (AMA) *Directory of Practice Parameters* was reviewed to identify published medical recommendations concerning the diagnosis and treatment of CTS.<sup>11</sup>

CTS is listed in the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* as code 354.0, which includes median nerve entrapment and partial thenar atrophy. It is part of the category entitled mononeuritis of the upper limb and mononeuritis multiplex. The terms cumulative trauma disorder, occupational overuse syndrome, repetitive motion disorder, and repetitive strain injury are less specific and are not included in *ICD-9-CM* as diagnostic terms.<sup>5</sup> Therefore, CTS is the term most specific for medical diagnoses and will be used except where another term is specifically cited.

Nine medical societies in the United States published clinical recommendations or scientific statements concerning the diagnosis and/or treatment of CTS (Table).<sup>4,12-22</sup> In addition, three United States government agencies have issued statements concerning CTS. The

Office of Technology Assessment discussed CTS as part of a general review of occupational illnesses and injuries, the National Institute for Occupational Safety and Health (NIOSH) issued recommendations on the definition of CTS, and the Occupational Safety and Health Administration (OSHA) issued formal recommendations concerning the diagnosis and treatment of CTS.<sup>1,8,23,24</sup>

Eight national medical organizations have published statements concerning the use of diagnostic tests for CTS. In evaluating a patient for CTS, the minimum recommendations include obtaining a medical and occupational history and performing a physical examination focused on the upper extremity. Hematologic, serologic, endocrinologic, and radiographic tests are recommended when they are clinically indicated to evaluate for conditions and systemic diseases that may be contributing to the onset of CTS. In addition, therapeutic trials are considered indicated in certain circumstances. Sensory nerve conduction studies and electromyography generally are considered the standard of care when lab-



*Carpal tunnel syndrome (CTS) is a multifactorial, potentially disabling condition associated with dysfunction of the median nerve and tendons in the wrist carpal tunnel.*

**Table. Medical organizations in the United States with published statements concerning carpal tunnel syndrome.**

Medical organization	Type of statement	Year
American Academy of Neurology	Practice parameters	1993
American Academy of Orthopaedic Surgeons		
Subcommittee on Clinical Policies	Clinical policy	1991
Council on Clinical Resources	Workshop report	1992
American Academy of Physical Medicine and Rehabilitation	Practice parameter	1993
American Association of Electrodiagnostic Medicine	Practice parameter	1993
American Association of Neurologic Surgeons	Criteria for review	1993
American College of Occupational and Environmental Medicine		
Committee on Occupational Medical Practice	Occupational medicine forum	1991
Publications Committee	Book section	1994
American College of Rheumatology		
Glossary Committee	Dictionary; Workup guide	1982
Council on Rheumatologic Care	Guideline for reviewers	1992
American Public Health Association	Book chapter	1991
American Society for Surgery of the Hand	Position statement	1993

oratory confirmation is desired in patients suspected of having CTS on clinical grounds.<sup>13</sup> In the NIOSH surveillance case definition of work-related CTS, which includes at least one specific symptom and evidence of work-relatedness, electrodiagnostic testing either is in addition to or a substitute for specific objective physical examination findings.<sup>1</sup>

Six national medical organizations and one governmental agency have published statements concerning the treatment

and rehabilitation of patients with CTS. Generally, each organization recommends a therapeutic strategy that includes an initial conservative approach, with gradations of care and intervention. Conservative medical treatment generally consists of using oral medications (especially nonsteroidal, anti-inflammatory drugs), removing constrictions, modifying (restricting) activities to promote healing, and guided exercises. Wrist splints are not universally recommended. A wrist

splint is best used only in the neutral position and off-the-job or when it will not strain another joint. Splinting can result in a weakening of the muscle, loss of normal range of motion due to inactivity, or even greater stress on the area if activities are carried out while wearing the splint. The local injection of corticosteroids is included in the initial treatment course by some organizations and as an intermediate option by others. When used, a trial of corticosteroid injection, if therapeutic,

## *Organizational statements and recommendations concerning CTS diagnosis and treatment provide a benchmark with which to compare current clinical strategies.*

may assist in the diagnosis. Surgical treatment is reserved for patients with more advanced or refractory problems. Outpatient surgery generally is indicated, unless the patient has conditions that markedly increase the procedure's risk so that inpatient treatment is appropriate.

Diagnostic and therapeutic options for CTS have been evaluated or discussed by nine nationally recognized medical societies and three federal agencies. The findings have been tabulated to provide a benchmark with which to compare current clinical strategies in order to support the provision of the optimal level of care for workers suspected of or diagnosed as having CTS. For most statements, assessments, or recommendations reviewed, the professional organizations have noted that they are voluntary and not intended to set standards of practice, but rather represent a consensus at the time.<sup>12,13,16,17</sup>

CTS is a compression neuropathy characterized by sensory and motor dysfunction. The minimum recommendations for evaluation include obtaining a medical and occupational history and performing a focused physical examination of the upper extremity. Provocative tests include using

wrist percussion (Tinel's sign), which may be more specific, and wrist flexion (Phalen's sign), which may be more sensitive.<sup>6</sup> These may be of limited value by themselves, however, and may be best used as part of a test battery.<sup>25,27</sup> OSHA includes a body diagram in its guidelines, but not a detailed hand diagram.<sup>24,28</sup> The NIOSH surveillance case definition is best used for public health surveillance and not for diagnosis, because its positive predictive value for individuals, when not coupled with nerve conduction studies, was only 0.22.<sup>29,30</sup>

Diagnostic tests to evaluate for conditions and systemic diseases that may be contributing to the onset of CTS should be performed when clinically indicated. Of the diagnostic tests for CTS, median nerve conduction studies currently are considered the gold standard.<sup>5,13,29,31</sup> These tests are valid and reproducible and confirm a clinical diagnosis of CTS in patients with a high degree of sensitivity and specificity.<sup>31</sup> Nerve conduction testing is used to measure whether the nerve is conducting more slowly (decreased velocity) or less efficiently (decreased amplitude), with sensory nerve testing having better predictive value than motor nerve testing.<sup>31</sup>

Recent NIOSH monographs detail the technical uses of electromyography and nerve conduction testing,<sup>32,33</sup> and an American Association of Electrodiagnostic Medicine report provides guidance concerning its clinical use in CTS.<sup>31</sup>

The recommended therapeutic strategies generally include an initial conservative approach, with gradations of care and intervention. Patients should be given the option of conservative care, unless individual patient circumstances dictate a more aggressive and invasive course of treatment. Emerging technologies may prove useful but need to be tested, validated, and found to be cost beneficial prior to wide-scale use. Diagnostic techniques in this category may include detailed hand diagrams, computed tomography, magnetic resonance imaging, Semmes-Weinstein monofilament testing, thermography, ultrasonography, and vibrometry. Some of the options, such as endoscopically guided release of the transverse ligament, may be indicated for individual patients based on additional experience. Other therapeutic techniques that need further testing and validation include iontophoresis and balloon angioplasty.



## Sensory nerve conduction studies and electromyography are considered the standard of care when laboratory confirmation is desired in patients suspected of CTS on clinical grounds.

In addition to the medical care discussed, a worker diagnosed with CTS may need to have an ergonomic evaluation and, if necessary, interventions instituted in the workplace to eliminate or minimize physical circumstances that could exacerbate the condition. These ergonomic interventions should be part of a systems approach to safety and health management in the workplace and are discussed elsewhere.<sup>5,9,24,34,36</sup> A person with CTS also may need to institute ergonomic improvements in nonwork-related activities and the home environment.

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*Patients should be given the option of conservative care, unless individual patient circumstances dictate a more aggressive and invasive course of treatment.*

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# RADIOLOGY/PATHOLOGY CONFERENCE: MESENTERIC CYSTIC LYMPHANGIOMA

Athena H. Lantz, MD  
Lori Goodell, MD  
John L. Nosher, MD

The authors are affiliated with UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Drs. Lantz and Nosher are with the Department of Radiology and Dr. Goodell is with the Department of Pathology.

**Clinical history.** A 19-year-old male presented with a four-month history of fatigue, anorexia, left lower quadrant abdominal pain, and a 20-pound weight loss. There was no significant past medical history. The patient denied any fever, change in bowel habits, dysuria, hematuria, nausea, vomiting, or diarrhea. Physical examination revealed a cachectic young man with a large, palpable, nontender, abdominal mass. Laboratory evaluation was noncontributory. A contrast-enhanced computed tomography (CT) scan was performed following which the patient underwent surgical resection of a large intra-abdominal mass.

**Radiologic findings.** A CT scan of the abdomen, performed following the administration of both oral and intravenous contrast, revealed a

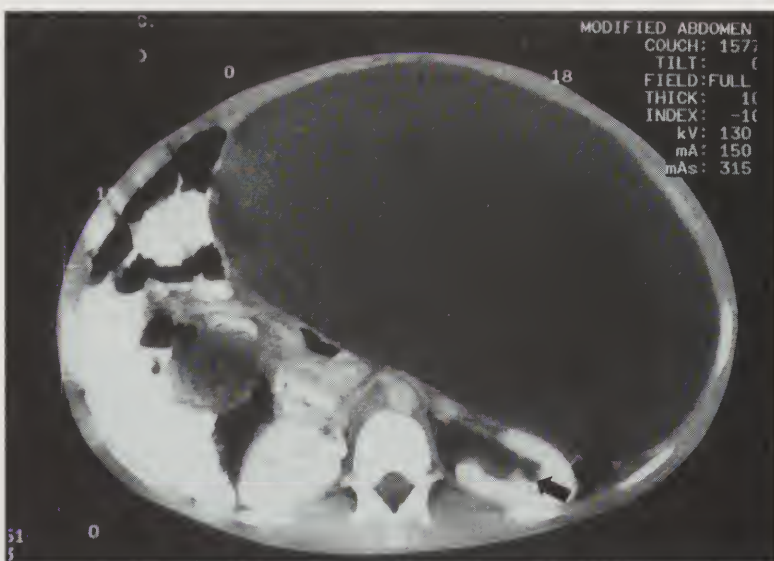
50 x 30 x 15 cm multiloculated intraperitoneal mass of low attenuation with internal septations (Figures 1 and 2). Hydro-nephrosis of the left kidney was present secondary to extrinsic compression of the right ureter by the mass (Figure 2).

**Pathology.** A 34-pound, multicystic mass measuring 55 x 30 x 15 cm was resected along with a segment of small intestine. The cyst contained brown-colored fluid and had a thin wall measuring from 0.2 to 0.5 cm in thickness (Figure 3).

Light microscopy demonstrated endothelium-lined cystic spaces with irregular lumina and widely spaced nuclei sur-

rounded by fibrous tissue fascicles, poorly developed smooth muscle, and lymphoid aggregates. These histological features distinguished lymphangioma from hemangioma. Electron microscopy revealed a poorly developed, discontinuous basal lamina and anchoring fibrils between endothelial cells and underlying collagen fibers. These findings were diagnostic of a cystic lymphangioma (Figure 3).

**Discussion.** Lymphangiomas are benign, endothelium-lined cystic lesions. They occur most commonly in children and young adults, but have been reported in all age groups.<sup>1</sup>

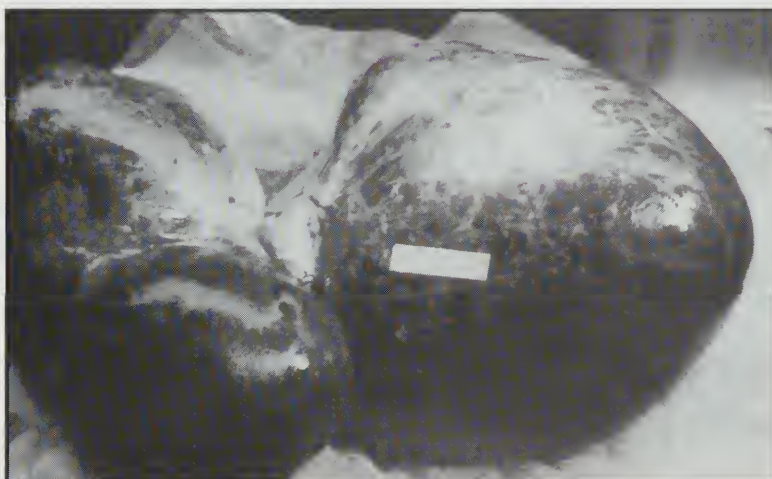


**Figure 1.** Contrast-enhanced CT through the mid-abdomen demonstrates a large intraperitoneal mass of low attenuation that causes displacement of bowel loops to the right (small arrow).

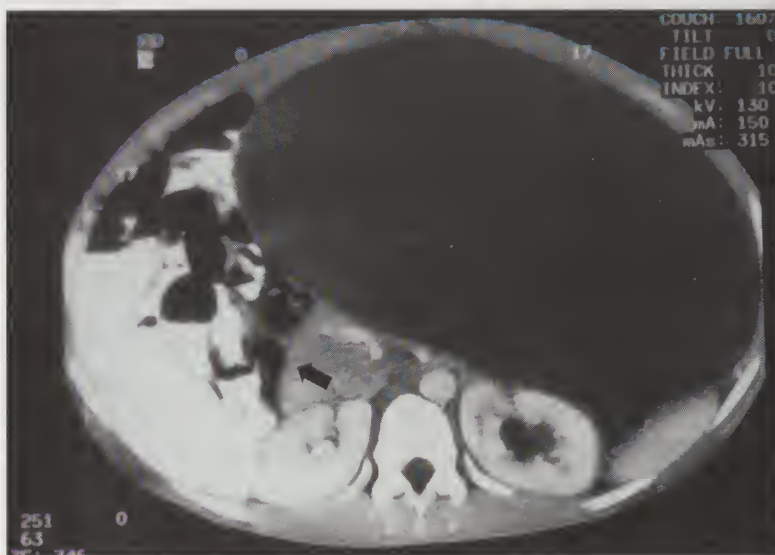


The most common sites of involvement are the neck and axilla, which account for greater than 50 percent of all reported cases, with other sites of involvement including the extremities, trunk, axilla, spleen, bone, and retroperitoneum.<sup>5</sup> Abdominal lymphangiomas are rare and most commonly located in the mesentery of the small bowel followed by omentum, mesocolon, and retroperitoneum, secondary to its rich lymphatic network. Although 60 percent are present in patients under five years, they can manifest in adulthood.<sup>9</sup>

Patients present with varying symptoms that include a painless increase of abdominal girth, chronic abdominal pain, tenderness upon palpation, or an acute abdomen.<sup>4</sup> Patients with large lesions are more likely to present with an acute abdomen resulting from bowel compression and acute obstruction.<sup>7</sup> Other symptoms include vomiting, nausea, constipation, or diarrhea.<sup>4</sup>



**Figure 3.** The gross photograph of the surgical specimen illustrates a 34-pound multicystic mass that measured 55 x 30 x 15 cm.



**Figure 2.** Marked hydronephrosis of the left kidney is observed (small black arrow).

It is postulated that retroperitoneal lymphangioma is a developmental anomaly of lymphatic vessels that fail to establish normal communication with the remaining lymphatic system, thus resulting in dilated lymphatic channels. This theory has been validated by reports of chylous material in the cysts with CT values equal to that of fat as well as opacification of

the cysts following pedal lymphangiography.<sup>5,8</sup>

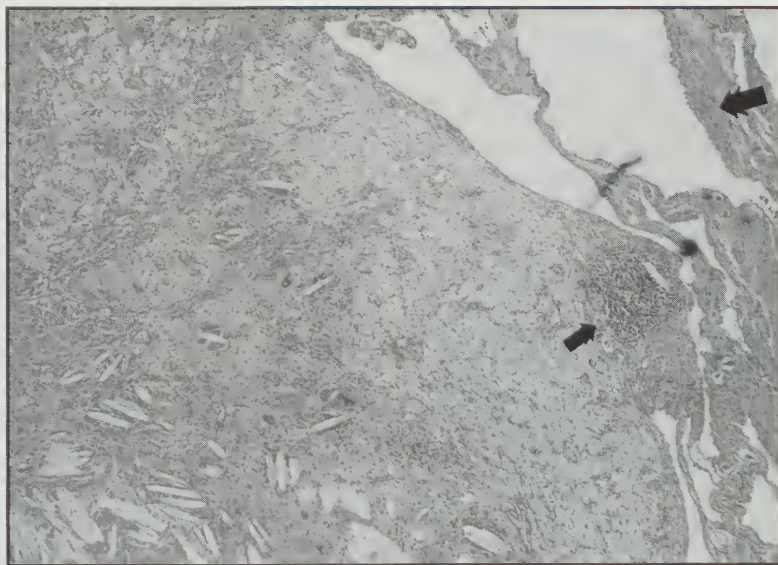
The differential diagnosis of cystic intra- and retroperitoneal masses include pancreatic pseudocysts and cystic pancreatic neoplasms, enteric duplication cysts, mesothelial cysts, cystic mesotheliomas, mature teratomas, urinomas, lymphoceles, and loculated ascites. Mesenteric lymphangiomas are cystic and may be unilocular or multilocular. The content of the cyst may be serous or chylous. Sonography and CT and magnetic resonance help differentiate between an intraperitoneal or retroperitoneal location of the lesions,<sup>6</sup> although this differentiation may be impossible with very large lesions.

With CT imaging, most cystic lymphangiomas display capsular enhancement following contrast injection. CT features of lymphangioma that allow differentiation from ascites include separation of

bowel loops, absence of fluid in the perihepatic spaces and cul-de-sac, and focal septations.<sup>2</sup>

Sonography and CT help characterize the internal contents of the cysts. The cystic fluid has ultrasonic and CT appearance similar to water, but occasionally contains solid elements indicating the presence of infection or hemorrhage. An infected cystic lymphangioma may demonstrate a thickened cystic wall on CT, although the presence of an enhancing thick wall usually indicates that the lesion is either a pseudocyst or an enteric duplication cyst.<sup>5</sup> Chylous contents and mural calcifications have been reported, but are uncommon. The presence of lipid-containing fluid makes differentiation between mature teratoma and cystic lymphangioma difficult. With MR, serous-containing cysts appear hypointense on T<sub>1</sub>-weighted images and hyperintense on T<sub>2</sub>-weighted images. Cysts with hemorrhagic or fatty contents appear hyperintense on T<sub>1</sub>- and T<sub>2</sub>-weighted images.<sup>3,6</sup>

Treatment of cystic lymphangioma is complete surgical excision, often requiring small bowel resection with mesenteric lymphangiomas. Percutaneous drainage of the cysts is of no therapeutic value. Retroperitoneal lymphangiomas often are not amenable to complete surgical resection and are sometimes managed conservatively. Occasional recurrence after surgical resection has been reported.<sup>7</sup>



**Figure 4.** Light microscopy illustrates the lymphoid aggregates (small black arrow) as well as poorly developed smooth muscle (large black arrow).

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**NJM**



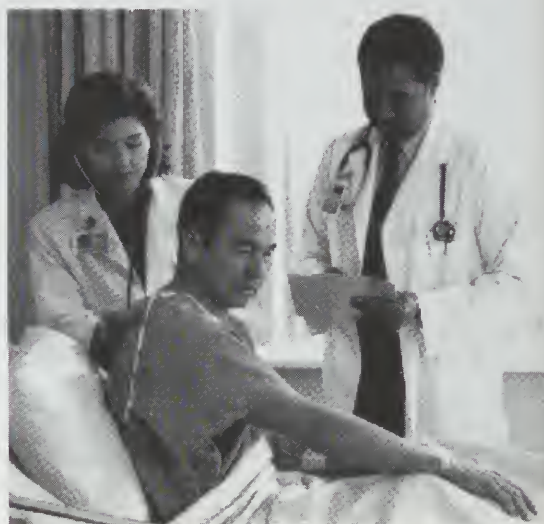
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# CHEST RADIOGRAPHS IN PATIENTS WITH COMMUNITY-ACQUIRED PNEUMONIA

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Sara L. Wallach, MD  
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The utility of serial chest radiographs (CXR) in the treatment of the hospitalized patient with community-acquired pneumonia has not been extensively studied.<sup>1-7</sup> Preoperative and admission CXRs have not been found to be cost effective, and should be restricted to patients with clinical evidence of underlying disease or patients who are planning to have intratho-

racic surgery. In patients with pneumonia, CXRs can confirm the presence and location of pulmonary infiltration as well as help assess the extent of infection.<sup>2</sup> At times, CXRs may help define the casual organism.

There is a broad consensus among physicians that patients with radiographically proven pneumonia should have a followup CXR six weeks after discharge from the hospital to confirm the complete resolution of the original infiltrate.<sup>6,8</sup> However, in their classic study on *Streptococcus pneumoniae*, Jay, Johanson, and Pierce did not attempt to examine either the reasons for ordering followup CXRs nor the effect they had on patient management.

While it is recommended that radiographs should be taken if the patient does not respond clinically or deteriorates,<sup>2,9</sup> and again before discharge,<sup>9</sup> there is a dearth of published data to substantiate these recommendations.

To further clarify the role of serial CXRs, we investigated the relationship between the

ordering of CXRs and changes in patient management. Further, we sought to establish specific criteria that would justify ordering followup radiographs.

*Methods.* The records of all patients with the admission diagnosis of pneumonia admitted to the medical service of a large community teaching hospital between July 1, 1992, and December 31, 1992, were retrospectively reviewed. All initial diagnoses of pneumonia were confirmed by an initial CXR report as evaluated by the hospital's department of radiology. As all information already was in existence and was kept confidentially, no informed consent was necessary.

Specifically excluded from the study were patients with no initial admission CXR revealing an infiltrate, congestive heart failure (CHF), chest tubes, pneumothorax, and pleural effusions unrelated to pneumonia and those patients who developed hospital-acquired pneumonia. Neutropenic patients and patients on ventila-



*The present study of CXR in hospitalized patients with community-acquired pneumonia demonstrates that close to 90 percent of CXRs do not result in any change in patient management.*

tors were excluded as the use of x-ray in these populations has been evaluated and shown to be effective.<sup>10,11</sup> Finally, those initially admitted to other services were excluded.

Demographic information such as age, race, sex, insurance, smoking history, alcohol history, admission to resident or nonresident coverage bed, intensive care unit (ICU), or regular floor bed, along with any associated comorbid conditions, was extracted from patient charts.

All CXR reports then were evaluated by the physician reviewers as to whether the results were improved, unchanged, or worse, according to the official radiology report.

Any clinical reason for a CXR order as stated either in the progress notes or the order sheet was obtained. A general order of followup was not considered to be a valid clinical reason, although it was noted for data analysis purposes. The results of the CXRs were correlated with the following clinical conditions: cough, chest pain, rales, wheezes, rhonchi, fever,

tachypnea, and tachycardia. Medications were categorized as antihypertensives, steroids, and chemotherapeutic agents. Laboratory data were collected as follows: reason (if given), white blood count (WBC), plus differential, anion gap, arterial blood gases (ABG), and pulse oximetry. Sputum and blood culture results, if positive, also were included.

### Abbreviations

<b>ABG</b>	<b>= Arterial blood gases</b>
<b>CHF</b>	<b>= Congestive heart failure</b>
<b>COPD</b>	<b>= Chronic obstructive pulmonary disease</b>
<b>CXR</b>	<b>= Chest radiograph</b>

Determinations as to whether a CXR resulted in a change of management came directly from the progress notes. A change in management was recorded if any of the following occurred: change in antibiotics (either by route, dosage, or type), a procedure was ordered (defined by bronchoscopy, thoracentesis, pleur-

al biopsy, computed tomography [CT] scan), consultation was obtained, or the patient was transferred or discharged. No change in management was recorded if none of the above occurred or if there was no mention in the progress notes that the CXR had an impact on the clinical decision. The review of the chart was terminated if the patient developed any of the exclusion criteria while in the hospital, but all CXRs were included up until termination.

Statistical analysis of categorical variables was performed using a chi-square or Fisher's exact test; continuous data were analyzed using Student's t-test. Significance was considered at the 95 percent level (two-sided).

**Results.** From 190 patients with a discharge diagnosis of pneumonia during the specified time period, 72 met the inclusion criteria. The mean age of the excluded 118 patients (63 females, 55 males) was 66.7 years (with a standard deviation of 17.9). For the 72 included patients (55 percent females, 45 percent

*Contrary to other studies, age did not play a role, although several clinical and laboratory variables did result in suggestive though not statistically significant trends.*

males), the mean age was 61.5 years (+/-19.7). Therefore, the excluded and included population was not statistically significantly different with regard to age or gender.

The patients whose charts were reviewed received a total of 166 CXRs (after the initial CXR), with a median of 2 (range: 1-10). Of the 166 CXRs, 147 (88.6 percent) did not result in a change in antibiotic, procedure, consultation, or discharge (no change group); only 19 (11.4 percent) resulted in any change in management (change group).

The changes that occurred were the initiation of diagnostic procedures in 11 cases, antibiotic changes in 4 cases, and 1 case each of consulting a subspecialist, transferring the patient, ordering further blood work, and discharge. The ordered diagnostic procedures consisted of bronchoscopy and thoracoscopy in 6 cases and chest CT scan in 5 cases.

There were no statistically significant differences between groups with regard to demographic variables (Table 1), although the mean age was 10 years higher in the change than

**Table 1. Baseline characteristics by group.**

Variables	No change n = 147	Change n = 19	P value
Age	60 (s.d.:15)	70.3 (s.d.:20)	.132
Sex			
Female	61 (43%)	12 (63%)	.083
Male	84 (57%)	7 (37%)	
Race			
White	114 (80%)	16 (84%)	.644
Nonwhite	29 (20%)	3 (16%)	
Teaching			
Yes	134 (92%)	15 (83%)	.189
No	11 (8%)	3 (17%)	
Smoking (Pack per year)	.34	.21	.483
Insurance*			
Medicaid/Medicare	41 (67%)	6 (60%)	-
Private	11 (18%)	4 (40%)	
Unknown	9 (15%)	0 (0%)	

In each category the sum of the numbers does not equal the total number of 147 in the no change category and 19 in the change category because of missing data.

\*Insurance is recorded by number of patients, not number of radiographs.

in the no change group. There were more changes made in the management of female patients, but this difference did not reach the level of significance.

When the clinical symptoms, signs, laboratory data, and CXR results in the two groups were compared, again no statistically significant differences were found. There were 43 (31 percent) improved, 74 (53 per-

cent) unchanged, and 22 (16 percent) worsened CXRs in the no change group compared to 6 (35 percent) and 5 (30 percent), respectively, in the change group.

The presence of diabetes mellitus, neoplasms, and coronary artery disease did not appear to have any effect. Patients with chronic obstructive pulmonary disease (COPD) had a rate of change in manage-



*All information came from chart notes, which may not fully reflect a physician's clinical reasoning. However, the vast majority state no reason for ordering a chest radiograph.*

ment three times that of non-COPD patients, while patients with HIV and those receiving chemotherapy or steroids had fewer changes.

Finally, the progress notes indicated a reason for ordering the CXR only in 28 cases (16.9 percent); of these, 24 cases were a clinical or laboratory reason (worsening of clinical status, persistent cough, worsening WBC count) and 4 cases were to rule out CHF (Table 2). Of the 138 CXRs considered to have no explicit reason for having been ordered, 31 were labeled as followup. In the remaining 107 cases (64 percent) there was no indication at all in the progress notes. There was no correlation between clinical reasons for ordering a CXR and subsequent changes in management.

**Discussion.** This study of CXR utility in hospitalized patients with community-acquired pneumonia demonstrates that close to 90 percent of CXRs ordered did not result in any change in patient management. Of the 19 changes made after a CXR, however, the majority were procedure oriented. Subgroup

**Table 2. Reason for ordering CXRs.**

Reason	Number	Total
None		
Not Given	107	
Followup	31	138
Clinical		
General	24	
Rule Out CHF	4	28

analysis revealed no demographic, laboratory, or clinical reasons for ordering a CXR that were associated with a resulting change in management. Given the perspective that technologic procedures too often supplant clinical judgment,<sup>12,13</sup> these findings indicate that this is an area where physicians can utilize limited resources more efficiently, with the result being more directed and effective care.

Contrary to other studies, age did not play a role, although several clinical and laboratory variables did result in suggestive, though not statistically significant, trends.<sup>3,8</sup> Clinically, only 1 out of 26 (3.9 percent) CXRs ordered on patients with improved rates resulted in a management change; similarly, clinical im-

provement in both rhonchi and dyspnea appeared to correlate with no management change. Neither the fever nor the tachycardia categories revealed any significant patterns. Most of the CXRs ordered in patients showed no clinical changes. WBC and other laboratory data were not helpful in determining if a CXR would result in any management change. In addition, while patients with COPD might benefit from serial radiographs, data on patients with HIV as well as those on steroids and chemotherapeutic agents suggested that serial CXRs would not alter patient management. Although the proportions found are not statistically significant, they may warrant further attention.

All information came from chart notes, which may not fully

*A prospective study must be undertaken to determine the clinical and/or laboratory variables for which serial CXRs in patients with community-acquired pneumonia are indicated.*

reflect a physician's clinical reasoning. However, the vast majority stated no reason for ordering a CXR (Table 2). Even if all CXRs ordered without an obvious clinical or laboratory reason are excluded from analysis, less than 10 percent of the remaining CXRs resulted in a change in management, which is consistent with our overall findings.

As in any retrospective study, data were not available for all patients in all categories, which limits the statistical analysis. Despite these limitations, this investigation, the first to quantify the issue, clearly has important implications for CXR utilization. Before any guidelines can be considered, a prospective study must be undertaken to determine the clinical and/or laboratory variables for which serial CXRs in patients hospitalized for community-acquired pneumonia are indicated.

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Robert M. Confer

## MANAGEMENT AND DISPOSAL OF MEDICAL WASTE

*Due to efficiency and the elimination of certain regulations, the Department of Environmental Protection is proposing to lower registration fees for generators of medical waste.*

**Mr. Confer is chief of the Bureau of Technical Assistance for the Department of Environmental Protection, the Division of Solid and Hazardous Waste.**

In August 1988, emergency regulations were enacted following a second season of medical waste wash-ups on beaches. As New Jersey participated in a two-year EPA demonstration program established by the federal Medical Waste Tracking Act of 1988, the state Legislature passed the Comprehensive Regulated Medical Waste Management Act in March 1989 and readopted its emergency rules in June 1989.

Since then, the Department of Environmental Protection (DEP) and the Department of Health have been charged with developing and implementing a statewide medical waste management plan that addresses New Jersey's needs with regard to the management and

disposal of specific types of medical waste in a manner that protects public health and the environment.

In response to suggestions from the regulated community and in keeping with DEP's initiative to streamline its regulatory programs, DEP is proposing regulated medical waste (RMW) amendments and new rules that relax some of the current regulations and promote more efficient and economical collection and transport of RMW. DEP recognizes that some of its current requirements need to be updated, and made less burdensome and costly. Furthermore, the level of compliance by the regulated community is a clear indication of its commitment to ensuring that medical waste disposal in New Jersey does not pose undue risks to public health or the environment. Indeed, the cooperation from the health care and waste disposal industries is such that some of the current regulations no longer are necessary. The following highlights

some of the forthcoming changes proposed to the regulations for generators of RMW.

As both program efficiencies and the elimination of certain regulations will result in a cost savings, DEP is proposing to pass such savings on to generators in the form of lower registration fees. The registration fees for all generator categories will decrease by 15 percent. For example, the \$100 registration fee for generators that produce less than 50 pounds of RMW per year will be lowered to \$85 per year. For those generators that generate RMW in excess of 1,000 pounds per year, the fee will decrease from \$3,500 to \$2,950. In addition to lower generator fees, DEP also is proposing a reduced annual fee for noncommercial transporters, such as hospitals that transport their own waste. The proposed regulations reduce the current \$3,957 registration fee to \$650. Destination facilities also will be charged lower registration fees. For example,



*The Department of Environmental Protection informed generators in December 1995 that they no longer were required to maintain logs for the medical waste they produce.*

the proposed fee for small businesses that treat and destroy less than 1,000 pounds of RMW per year is \$50 from \$2,046. For facilities treating and destroying more than 1,000 and less than 10,000 pounds of RMW per year, the proposed fee is reduced from \$2,046 to \$500. DEP also will eliminate the fee requirement for noncommercial facilities generating less than 10,000 pounds of RMW per year that send treated RMW off site for disposal.

In an effort to reduce paperwork for generators, DEP informed generators in December 1995 that they no longer were required to maintain logs for the RMW they produce. Generators were advised that while disposal frequency is at the discretion of the generator, generators should store RMW on site no longer than one year to prevent on site occupational safety hazards from developing from the accumulation of RMW. These policies are incorporated in the proposed amendments to the RMW regulations.

DEP is modifying the definition of RMW to specify that plastic blood vials are included

in Class 3—Human Blood and Blood Products. This change recognizes that plastic vials cannot shatter or break as with glass vials and, therefore, do not require the type of management required for sharps in Class 4. Carpules will be listed in the definition of sharps so as to eliminate confusion concerning their regulation. The description of sharps has been revised to clarify that sharps will include sharp, or potentially sharp if broken, items such as hypodermic needles, and syringes, and their components, including those items from manufacturing and research activities.

The proposed rules will exclude certain biological and nonbiological materials that are used, reused, or recycled into other products from the definition of RMW. However, materials classified as Class 6—Isolation Waste will not be excluded from regulation and DEP will require that sharps be destroyed at the site of generation when they are shipped off site for recycling of their component raw materials in order to prevent them from causing harm or being used for illegal purposes. Materials that are

used, reused, or recycled must be reported to DEP and the district solid waste agency, which compiles data on the amount of materials recycled in their district.

DEP is proposing a number of exemptions intended to minimize paperwork and costs. An amendment proposes that owners and operators of multiple registered generating sites, such as school districts and local health agencies, be allowed to transport RMW from their various sites to disposal facilities. This is a practice DEP has sanctioned since the inception of the medical waste regulations. In those cases where certain small generators share the same room with another generator, they no longer will be required to individually package and use a tracking form for their waste. This exemption would apply where waste is produced in the specific room used by each generator where medical treatment, diagnosis, or immunizations occurs and when less than 500 pounds is generated per year. DEP proposes that packages of RMW be sent certified mail instead of the more costly registered mail.

# COMMENTARY

## Managing the rise of managed care in New Jersey

Over the last three years, managed care has enjoyed a meteoric rise in New Jersey and now is the most popular type of health benefit plan among New Jersey employers. Managed care plans accounted for 53 percent of all plans in use by New Jersey employers in 1995, up from 27 percent in 1993, according to results of the New Jersey Business & Industry Association's (NJBIA) third annual Health Benefits Survey.

The spread of managed care, made possible by sweeping health care reforms enacted by New Jersey in 1992, is having an enormous impact on the way health care services are delivered in New Jersey, an impact that is being felt by all—from doctors, nurses, and patients to hospitals, insurance companies, and employers.

In its role as the state's largest employer advocate, NJBIA has enthusiastically supported managed care as a concept. For more than a decade, NJBIA's member companies have identified the cost of health benefits as one of their most troublesome problems. NJBIA believed that the state's 1992 reforms—deregulating hospital rates and making health insurance more available to and affordable for small employers—would pave the way for the rapid expansion of managed care. With the spread of managed care, the cost of health benefits, driven by double digit inflation in the past, would moderate and perhaps even fall. This was our belief, based on the experience of other states.

In addition to documenting the rise of managed care in New Jersey, the results of our 1995 Health Benefits Survey provided evidence that managed care systems have put the brakes on health care inflation. Overall, health benefit costs rose by 1 percent for all survey respondents in 1995, the lowest rate of inflation since this survey was started in 1993. Costs fell by nearly .5 percent for all managed care plans last year, after falling by 1 percent in 1994, making cost deflation a reality for many employers.

*Christopher Biddle*

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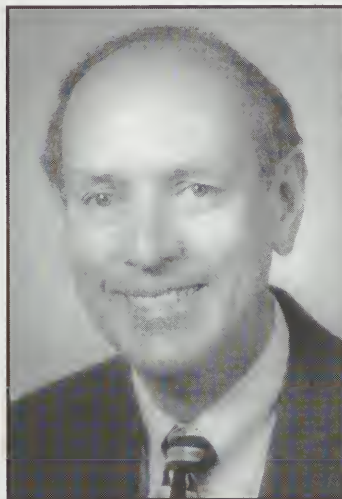
Although the rise of managed care in New Jersey clearly has benefited employers, managed care systems are not without their critics or shortcomings. Unfortunately, this has resulted in a raft of proposed anti-managed care legislation that could undermine or even destroy managed care in New Jersey.

NJBIA's goal, as the state's largest business representative, is to encourage the growth of managed care systems that provide quality health care at a reasonable price. It goes without saying, however, that managed care as a concept must be preserved as a choice if these benefits are to be realized. NJBIA, therefore, has developed a legislative agenda for 1996 that seeks to improve the quality of health care in New Jersey, while protecting managed care as a choice. This legislative agenda has three main prongs: blocking the passage of laws that would undermine managed care; discouraging the passage of benefit mandates that would escalate the cost of health benefits; and encouraging the state to create a system for publicly monitoring the quality of health care provided throughout the state. This agenda is detailed as follows:

*Preserve managed care as a choice.* A number of measures have been reintroduced in the 1996-1997 legislative ses-

sion that would alter the successful structure of managed care plans, and, in turn, drive up health insurance costs. NJBIA opposes all of the following bills: A-419 (Kelly), requiring managed care networks to accept any health care provider willing to meet the terms of their contracts; A-1047 (Doria),

requiring chiropractic services to be directly accessed by HMO enrollees; A-961 (Felice), requiring pharmaceutical companies to offer the same price to all buyers of equal volume; and A-2928 (Vandervalk, Cohen), imposing administrative regulations on HMOs.



Joseph E. Gonzalez, Jr., NJBIA president

*Create a mandated health benefits commis-*

*sion.* An advisory commission should be created, as called for in A-800 (Farragher, Garrett), which would analyze the financial, social, and medical impacts of current and proposed benefit mandates. Measures that require insurers to pay for specific treatments or services lead to increases in the cost of health insurance and should not be enacted until such a commission has been created to analyze them objectively. Examples include: A-1004 (Moran)/S-297 (Bennett), requiring coverage of Lyme disease, and A-201

## COMMENTARY

(Weinberg), requiring coverage for bone density tests.

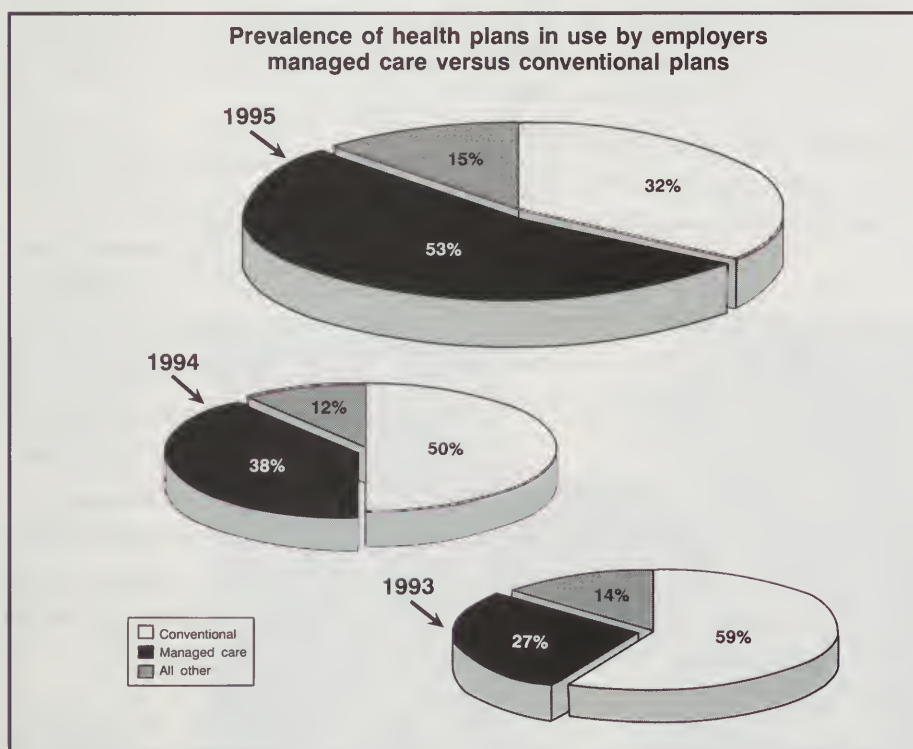
*Publicly monitor health care quality.* The New

Jersey State Department of Health (DOH)

already collects considerable data on the quality and outcomes of health care services provided in the state. NJBIA supports efforts by DOH's Health Data Committee to identify, collect, and distribute data on the quality and outcomes of health care services. Such information should be made available to employers and other purchasers of health care plans and services so they can make prudent choices for health care coverage.

Any legislation designed to improve the quality of health care services in New Jersey must be based on objective data and intelligent debate. NJBIA's annual Health Benefits Survey is valuable because it is the only statewide instrument that measures the experience of employers in providing health benefits to their employees. The following are highlights of the 1995 NJBIA survey:

The 1995 Health Benefits Survey was mailed to 14,000 member companies in October 1995. The results are based on the first 1,277 responses. The respondents, as a group, generally reflect NJBIA's membership profile. Survey respondents represented every industry in every region of the state.



Managed care is becoming New Jersey's most popular employer plan.



Fifty-four percent of the respondents were companies with 1 to 19 full-time employees; 23 percent were companies with 20 to 49 employees; 12 percent were companies with 50 to 99 employees; 9 percent were companies with 100 to 499 employees; and 2.5 percent were companies with 500 or more employees. This distribution is essentially the same as in 1994.

A primary finding of last year's survey is that employers continued to flock to managed care plans in New Jersey, making 1995 the first year ever in which more of those plans were purchased by employers than fee-for-service plans.

Fifty-three percent of all health benefit plans purchased by the survey respondents were managed care plans in 1995, up from 38 percent in 1994, and 27 percent in 1993. However, only 32 percent of plans purchased in 1995 were conventional plans, down from 50 percent in 1994, and 59 percent in 1993.

The fastest growing type of managed care plan in 1995 was the preferred provider organization, followed by point of service plans.

The average cost of all health benefit plans rose to \$4,493 per employee in 1995 from \$4,451 in 1994, an inflation rate of 1 percent. This minimal increase falls below the nation's medical cost inflation rate of 3.9 percent last year.

The 1 percent inflation rate for health benefit plans also is the lowest

rate of inflation in the three years since this survey was started. The average inflation rate for all benefit plans was 8 percent in 1994 and 6 percent in 1993.

Among the plan types, conventional plans were far and away the most expensive, costing an average of \$5,050 per employee, compared with a low of \$4,074 for preferred provider plans and an average of \$4,451 for all managed care plans.

Overall, a higher percentage of employers provided insurance coverage for employees in 1995 than did in 1994. Ninety-one percent of respondents provided some form of employee health benefits in 1995, up from 89 percent the year before. And 72 percent provided family coverage, up from 70 percent in 1994.

In an effort to control benefit costs, 35 percent of survey respondents asked employees to pay a larger share of those costs in 1995. This is less than the 47 percent of employers who asked workers to pay more in 1994. Another cost-control strategy popular among employers last year was to change plans, and in particular to switch to lower cost managed care plans. Thirty-seven percent reported joining a managed care network in 1995, and 27 percent reported changing plans.

Christopher Biddle is assistant vice-president, Communications, NJBIA.

## COMMENTARY

**NJM**

## MARKET SEGMENT SPECIALIZATION PROGRAM RAISES CRITICAL ISSUES

*Steven Bellows, CPA*

**Steven Bellows is a certified public accountant with a practice based in Matawan.**

Internal Revenue Service (IRS) examiners have entered the age of specialization. In an effort to provide guidance to examiners and familiarize them with specific industries, the IRS developed the market segment specialization program (MSSP). And with expenditures for health care accounting for 15 percent of our nation's gross domestic product, it comes as no surprise that the agency has developed an MSSP for the health care industry.

Of the many important issues discussed in the MSSP on health care, perhaps the three most critical issues for providers are the classification of workers: employees or independent contractors; the use of cash or accrual accounting; and unreasonably high compensation. Each of these issues can have significant implications for health care providers' taxable incomes.

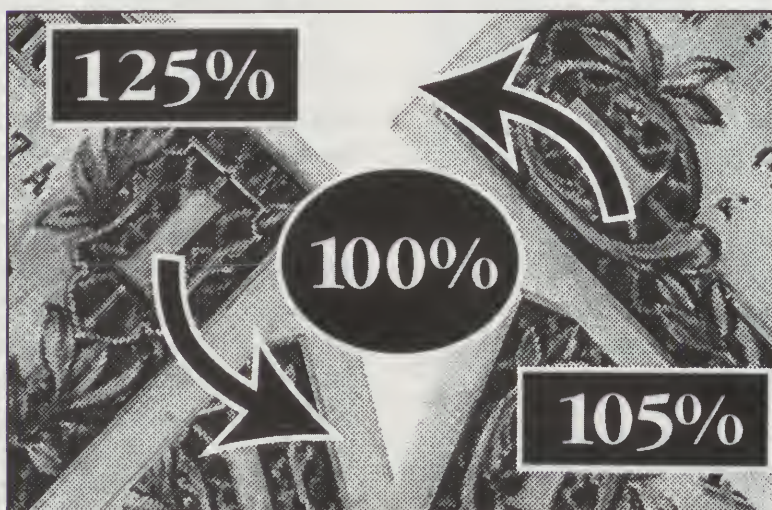
*Employees or contractors?* With respect to worker classification, the IRS believes that

health care providers may be misclassifying their workers as independent contractors rather than treating them as employees. The reasons for such misclassification are strictly economic. Both providers and workers benefit from the independent contractor classification. It is less costly for an employer to utilize the services of an independent contractor. The employer does not have to pay payroll taxes, and does not incur fringe benefits.

The worker also gains from this arrangement. No taxes are withheld from gross income, and the worker may qualify to deduct ordinary and necessary business expenses when calculating taxable income. In addition, an independent contractor

may establish a generous employee pension plan, which very often covers only that one worker.

In general, the classification of a worker as an employee is determined by the application of 20 common law factors. These factors, which concentrate on the degree of supervision and control exercised by the employer over the worker's activities, can be quite subjective. Whether the worker's services are integral to the provider's overall service offerings is one critical factor. If the services in question are vital to the success or continuation of the business, employer supervision and control are strongly implied.





*An important issue covered in the health care market segment specialization program is whether providers are entitled to use the cash method of accounting as opposed to the accrual method.*

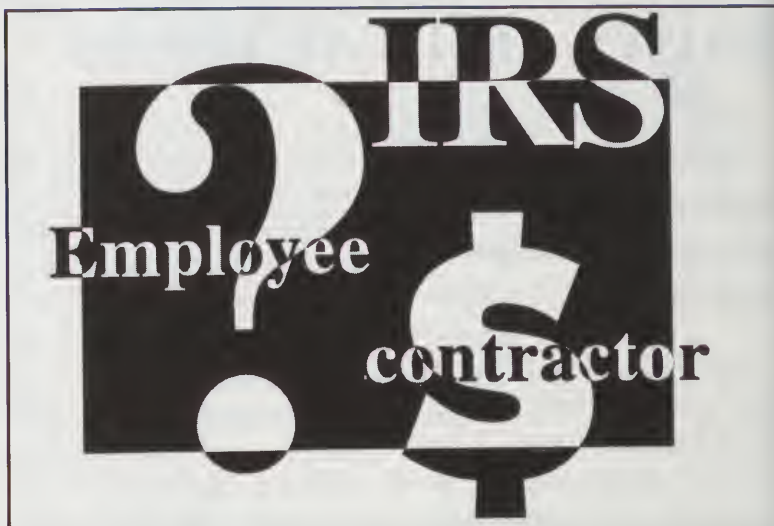
The amount of penalties and interest an employer will owe if the IRS finds worker misclassification depends on whether the IRS decides the misclassification was intentional. Intentional misclassification carries a much higher price tag.

An employer might still qualify for relief from federal employment taxes even though the IRS classified a worker as an employee if the employer had a reasonable basis for making the original classification.

Congress now is considering legislation to simplify the criteria for independent contractor status.

*Cash versus accrual accounting.* Another important issue covered in the health care MSSP is whether providers are entitled to use the cash method of accounting, as opposed to the accrual method. Under the cash method, actual cash receipts are used to calculate income for any given period, and only actual expense payments are used to calculate current expenses. Accounts receivable are not included in income until the payment is received.

Under the accrual method of accounting, accounts receivable are included as income at the time the services are pro-



vided; it doesn't matter when payment is received.

The IRS feels that while the health care industry traditionally has been considered a service industry, it is in fact a service/inventory mix industry. The Internal Revenue Code (IRC) generally requires taxpayers to use the accrual method when inventories are necessary to clearly reflect income.

According to the IRS, medical supplies take on the characteristics of inventory when the medical service cannot be provided without use of the supply item. The IRS specifically refers to prescription drugs as being an integral part of the service, and makes a similar reference to precious metals used in dental practices.

*Income-producing factor.* The IRS also takes the position

that drugs and supplies do not have to represent a substantial part of the provider's total income in order to be considered as inventory. They only need to be an income-producing factor. However, when inventory and inventory fluctuations are minimal, and have little or no effect on the provider's income, a change to the accrual method of accounting will not be required. Unfortunately, the health care MSSP does not specify what percentage of income represents a minimal amount.

Even when inventory is not an income-producing factor, the IRS could use another approach to require adoption of the accrual method of accounting. It could take the position that the cash basis of accounting does not clearly reflect income. It would then be up to

*According to the IRS, medical supplies take on the characteristics of inventory when the medical service cannot be provided without use of the supply item.*

the taxpayer to prove that the income reported is substantially identical to the income that would be reported using the accrual method. This would not be easy to prove, and the result could be additional tax liability for the health care provider.

If the provider decides it is prudent to change to the accrual method of accounting, the resultant adjustment to income might qualify to be spread over three years.

*Unreasonable compensation.* Another area of concern for health care providers is the question of whether the IRS considers the provider to be taking "unreasonably" high amounts out of the business in the form of wages. Since a corporation is the only business form that pays wages to its owners, this question affects only practices organized as a corporation.

A finding of unreasonably high compensation would result in increased tax liability to the corporation because a portion of the wages would be reclassified as nondeductible dividends. With the federal tax rate for personal service corporations currently set at 35 per-

### Accounting Methods

#### Cash Method

1. Actual cash receipts used to calculate income.
2. Actual expense payments used to calculate expenses.

#### Accrual Method

1. Include accounts receivable as income.
2. Expenses recognized when incurred.

cent, a reclassification of this type could be very expensive for the health care provider. The reclassified amounts therefore would be taxable to both the corporation and the recipient of the dividend.

This matter is of much less concern to corporations that have made an election to have corporate income taxed on the personal tax returns of their shareholders. A reduction in wages would be followed by a corresponding increase in corporate income—both of which already appear on the personal tax returns of the shareholders. In corporations with more than one shareholder, there is the possibility that a finding of unreasonably high compensation could result in a shift of income between the various shareholders.

*General office procedures and other issues.* In performing

their examinations, IRS field auditors will look at office procedures, the recording of patient appointments, and how the office records and patient billings reconcile with bank deposits.

In many instances, a health care provider will receive payments from more than one source for a single patient. The IRS considers this unique to the health care industry, and is very concerned that the provider may collect more than 100 percent of the amount billed without reporting the additional income. The IRS also feels that doctors could enter into agreements with insurance companies to allow the insurer to keep amounts that would normally go to the physician in exchange for personal insurance coverage for that doctor.

*This article gives a glimpse into the issues raised by the new health care MSSP. It is meant to provide a brief explanation of the program, and a few examples of the issues involved. Health care providers should consult CPAs or tax attorneys for a full analysis of the implications for their practices.*

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## SHOULD THE PROPOSED FDA RULES ON TOBACCO REGULATION BE ADOPTED?

Paul E. Wallner, DO

Dr. Wallner is chief, Department of Radiation Oncology, Cooper Hospital/University Medical Center. Dr. Wallner also is chair, New Jersey Breathes, and a member of the MSNJ Council on Public Health and of the MSNJ Council on Communications.

Thirty-two years after the initial surgeon general's report on the adverse health impacts of tobacco consumption, the American public finally is beginning to realize the unacceptable public health and economic impact of these products. In an effort to address some of these issues and concerns, the United States Food and Drug Administration (FDA) has proposed a series of rules designed to reduce access and appeal of tobacco products to children. In a desperate attempt to weaken and/or delay implementation of these rules, tobacco manufacturers, vendors, paid spokespersons, and surrogates have raised a number of spurious issues intended to draw the discussion away from public health and toward state's rights, individual civil liberties, and the increasing role of big government. As always has been the case with tobacco public relations activities, this represents a massive and expensive effort to control the direction of public debate.

First, the tobacco lobby dismisses the notion that the FDA has authority and responsibility to regulate

this legal product and accuses the FDA of inefficient practices in the past. This argument is inappropriate since the FDA is responsible for assuring that foods are safe, wholesome, and sanitary; that human and veterinary drugs, biological products, and medical devices are safe and effective; that cosmetics and electronic products that emit radiation are safe; that regulated products are honestly, accurately, and informatively represented; and that these products are in compliance with the law and FDA regulations.

The overwhelming body of evidence suggests that cigarettes indeed, are a nicotine-delivery device, and that nicotine is an addictive drug. Therefore, the FDA does have authority and responsibility in this area. Past practices of the FDA regarding the development and enforcement of food, drug, or equipment regulations are not the issue.

Second, the tobacco lobby argues that adults have a right to make the choice to smoke or not. Again, this is a

blatant attempt to subvert the issue of the actual proposed regulations, since they do not in any way infringe upon the rights of adults to acquire or consume tobacco products. The proposed regulations are designed specifically to reduce tobacco consumption by children under the age of 18 years of age, by limiting access to and reducing the appeal of tobacco products. The proposed rules would establish 18 years of age as the federal minimum age for

*The proposed  
FDA rules,  
are timely,  
reasonable,  
and necessary.  
They deserve  
the full support  
of all  
physicians  
and every  
American.*



sale and would prohibit cigarette vending machines, free samples, mail order sales, and self-service displays. Retailers would be required to verify age of purchasers and limit sales to face-to-face contact. Advertising and labeling would be limited by banning outdoor advertising within 1,000 feet of schools and playgrounds, restricting ads to text-only format, prohibiting distribution of "trinkets and trash" with tobacco brands, names, or imagery, and restricting sponsorship of events to corporate names only. Manufacturers would be required to establish and maintain a national public education campaign. The proposed rules do not address issues of excise taxes, warning labels, or environmental tobacco smoke.

Third, the tobacco lobby proposes that the burden be placed on the consuming children rather than on manufacturers and vendors. This approach has been attempted in the past unsuccessfully. The tobacco lobby suggests that marketing is not directed specifically to children despite its use of sports figures, attractive and healthy young models, and cartoon characters. The tobacco lobby argues that age verification and face-to-face sales contact are unnecessary burdens on retailers despite the fact that there is clear evidence that in states with these existing (but unenforced) requirements, more than 75 percent of children make their own tobacco purchases.

As a society, we have for over 200 years accepted the notion that, in children under the age of 18 years, certain provisions and restrictions are appropriate for education, nurturing, and protection. To suggest that these children should be treated as adults with regard to a life-threatening, life-shortening substance is obscene. In 1996, cigarette consumption will account for over 400,000 deaths or approximately 20 percent of all mortality causes in the United States. Nearly all of this morbidity and mortality relates to habitual use of tobacco products begun prior to the

age of 18 years of age. More than 3,000 children become addicted to tobacco daily, more than 6 million children under the age of 18 years use tobacco products, more than 60 percent of tobacco consumers began prior to age 14 years, and more than 90 percent of tobacco consumers began their habit prior to age of 20 years. Illegal sale of tobacco products to children accounts for more than \$1 billion in annual corporate revenues. Children who begin smoking prior to age 15 years of age have a rate of cancer 19 times that of non-tobacco consuming teenagers. Between 1991 and 1994, there was evidence of a 30 percent increase in use of tobacco products among 8th graders.

With support of the current administration in Washington, DC, and the support of the American public nationally, we are faced with a unique opportunity to protect children from tobacco abuse and to significantly reduce tobacco-related morbidity and mortality. The proposed FDA rules are timely, reasonable, practical, and necessary. They deserve the full support of all physicians and every American concerned about the future health of our children.

*Editor's note. A lobbyist for the tobacco industry had agreed to write a response to our question, "Should the proposed FDA rules on tobacco regulation be adopted?" Initially, he agreed; at deadline, he declined to comment.*

*Dr. Wallner's essay represents one side of this controversial issue. Some think the regulations should reduce the access and appeal of tobacco products to adults. Many opponents of the regulations feel that individual civil liberties are being violated by having government intervene in this area.*

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June 11, 1996  
Jersey Shore Medical Center, Neptune  
908/775-5500

### **Non-Hodgkin's Lymphomas**

June 12, 1996  
St. Mary's Hospital, Passaic  
AMNJ, 609/275-1911

### **Neuropsychiatric & Psychosocial Aspects of HIV/AIDS**

June 12, 1996  
S. Ocean Cty. Hosp., Manahawkin  
AMNJ, 609/275-1911

### **Superficial Fungal Infections**

June 13, 1996  
Shore Memorial Hospital, Somers Point  
AMNJ, 609/275-1911

### **Advances in Gastroenterology Course**

June 15, 1996  
Bally's Park Place Hotel, Atlantic City  
609/848-1000

### **Peripheral Stem Cell Transplants**

June 18, 1996  
Jersey Shore Medical Center, Neptune  
908/775-5500

### **Diagnosis and Treatment of Type II Diabetes Mellitus**

June 19, 1996  
The General Hospital Center at Passaic  
AMNJ, 609/275-1911

### **Annual Meeting, ACEP-NJ Chapter**

June 19-21, 1996  
Trump Plaza Hotel, Atlantic City  
AMNJ, 609/275-1911

### **Vaccination and Immunization Issues**

June 25, 1996  
Our Lady of Lourdes Med. Ctr., Camden  
AMNJ, 609/275-1911

### **Management of ZDV Therapy**

June 26, 1996  
RWJ University Hosp. at Hamilton  
AMNJ, 609/275-1911

### **44th Annual Meeting, NJ Academy of Family Physicians**

June 26-29, 1996  
Bally's Park Place Hotel, Atlantic City  
AMNJ, 609/275-1911

### **Medical Problems of the Elderly**

June 26, 1996  
Trenton Psychiatric Hospital, Trenton  
AMNJ, 609/275-1911

### **How To Help Your Patients Stop Smoking**

June 26, 1996  
Essex County Pharm. Assoc., Nutley  
AMNJ, 609/275-1911

### **MSNJ Sports Medicine Seminar**

October 9, 1996  
MSNJ, Two Princess Road, Lawrenceville  
609/896-1766

### **Physicians and the Media**

October 19, 1996  
American Society of Journalists, NYC  
212/997-0947

### **Bioactive Lipids in Neural Plasticity**

October 28, 1996  
School of Osteopathic Med., Stratford  
UMDNJ, 609/566-6000

### **Clinical Pharmacology of Eicosanoids**

November 4, 1996  
School of Osteopathic Med., Stratford  
UMDNJ, 609/566-6000

### **Strategies for Identification of New Targets in Stroke Research**

November 22, 1996  
School of Osteopathic Med., Stratford  
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Date: June 14, 1996

Topic: "Hormone Replacement Therapy for Postmenopausal Women"

Speaker: Gloria Bachmann, MD

Date: June 21, 1996

Topic: "Antiviral Update"

Speaker: Spartaco Bellomo, MD

Date: June 28, 1996

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## Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.





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## *Here's what we are covering in July 1996*

- ⇒ How is computer technology enhancing the health care field?

Writer Sandra Starr of Princeton reviews the newest computer advancements taking place in the Garden State health care arena.

- ⇒ What are the state and national breast cancer trends?

Authors Drs. Zablow and Sanfilippo and Mr. Duncan, Saint Barnabas Medical Center, analyze breast cancer diagnosis and treatment data.

- ⇒ How are health care professionals dealing with the issue of biomedical ethics?

Noted attorney Paul W. Armstrong details the current attitudes in the Garden State about biomedical ethics. And, Joseph Fennelly, MD, highlights MSNJ's involvement in this discussion.

- ⇒ How is the New Jersey Hospital Association facing the recent changes in medicine?

NJHA President Gary Carter gives an overview of NJHA and its role in shaping health care policy.

- ⇒ How are New Jersey physicians treating Lyme disease?

In the Point Counterpoint column, leaders in the infectious diseases present their opinions on treating patients with Lyme disease.

- ⇒ Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.

(continued from page 64)

PCMS's physician of the year

Philip J. Jasper, MD, was honored by the Passaic County Medical Society as the 1996 Physician of the Year. Dr. Jasper is a urologist and is affiliated with Beth Israel Hospital, General Hospital Center at Passaic, and St. Mary's Hospital, all in Passaic. Dr. Jasper is a member of the MSNJ Board of Trustees and of the AMA; he also is a fellow of The Academy of Medicine of New Jersey. Dr. Jasper is a past-president of the Passaic County Medical Society.



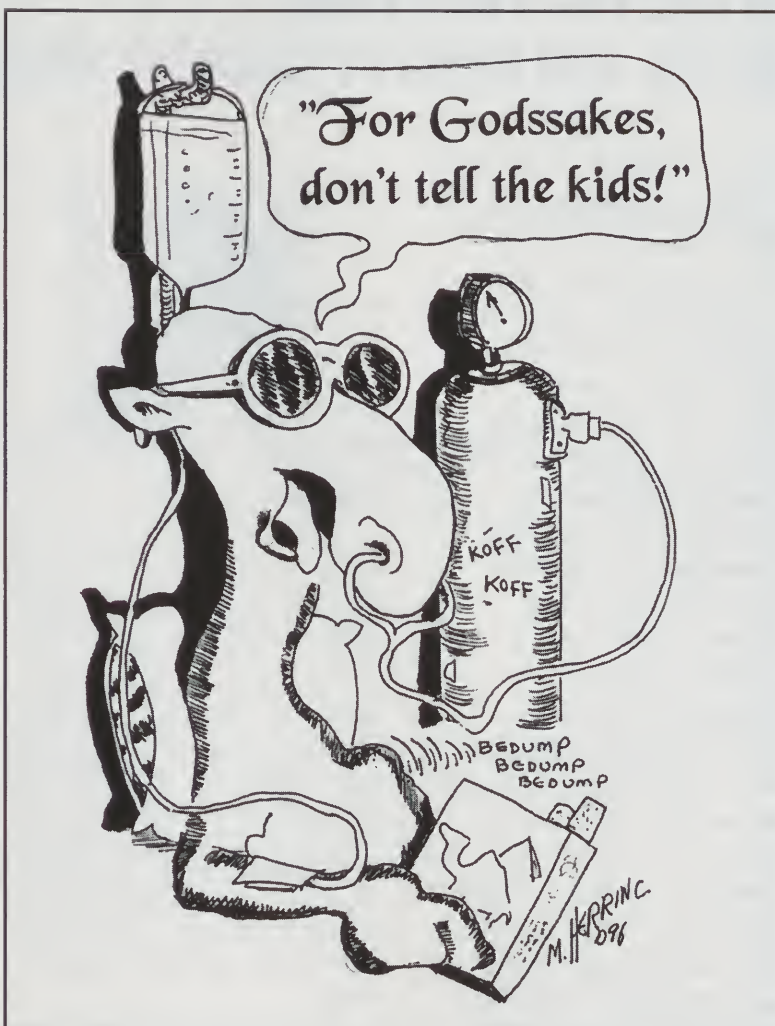
Andronaco appointment

John T. Andronaco, MD, of Franklin Lakes, has been named president of the medical staff at Hackensack University Medical Center. In this capacity Dr. Andronaco represents the interests of the medical staff and oversees quality assurance. Dr. Andronaco, an orthopedic surgeon, is a member of the Bergen County Medical Society. Previously, Dr. Andronaco was chair of the Department of Orthopedic Surgery at Hackensack University Medical Center.



Appointment at Saint Michael's

Peter A. Beaugard, MD, of Flemington, has been appointed director of the Department of Obstetrics and Gynecology at Saint Michael's



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine.

Medical Center, in Newark. Dr. Beaugard also serves as professor and chair of the Department of Obstetrics and Gynecology at Seton Hall University School of Graduate Medical Education, in South Orange. Dr. Beaugard is a member of the Passaic County Medical Society, the AMA, the American Society of Laparoscopists, and the Association of Professors of Gynecology and Obstetrics.

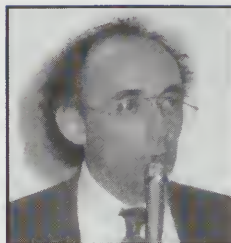
Kottler named referral specialist

The National Jewish Center for Immunology and Respiratory Medicine, in Denver, Colorado, has selected William F. Kottler, MD, of Warren, as a referral specialist. Parents in the tri-state area who contact the National Jewish Center for a referral for their children with respiratory illnesses may be referred to Dr. Kottler. Dr. Kottler is director of pediatric pulmonary medicine and medical director of the Children's Asthma Center at Saint Barnabas Medical Center, Livingston. He also is a member of MSNJ and the Essex County Medical Society. **NJM**



## WORKING TOGETHER: MSNJ AND COUNTY MEDICAL SOCIETIES

MSNJ announces the 1996 county medical society presidents: Jeffrey S. Pollack, MD, Atlantic; Joseph R. Friedlander, MD, Bergen; David A. Ingis, MD, Burlington; Joseph H. Reichman, MD, Camden; William R. Leisner, MD, Cape May; Catherine Wisda, MD, Cumberland; Alan J. Lippman, MD, Essex; Timothy Pilla, MD, Gloucester; Elpidio T. Marcelo, MD, Hudson; Harry M. Woske, MD, Hunterdon; Nicholas A. Rossos, MD, Mercer; Frederic F. Primich, MD, Middlesex; Vito M. Gulli, MD, Monmouth; Jeffrey A. Wexler, MD, Morris; Howard M. Berger, MD, Ocean; Frederic Wien, MD, Passaic; William Paterson, MD, Salem; Frank Sparandero, MD, Somerset; John Fisher, MD, Sussex; Errol Warner, MD, Union; and Robert C. Emery, MD, Warren.



Vincent K. McNerney, MD

### New AMNJ president

The Academy of Medicine of New Jersey announced its new president at ceremonies in Short Hills: Vincent K. McNerney, MD, of Passaic County. Dr. McNerney, an orthopedic surgeon, is chair of the MSNJ Committee on Medical Aspects of Sports. He practices in Paterson and Kinnelon and is affiliated with St. Joseph's Hospital and Medical Center, Paterson. The Academy provides physician-directed CME, and services for specialty organizations.



David I. Canavan, MD

### Citizen of the year

Medical director of the MSNJ Physicians' Health Program, David I. Canavan, MD, has been awarded the 1996 Citizen of the Year by the New Jersey Psychiatric Association. Dr. Canavan was honored for "the value of his work, and the way he does it." Under his directorship since 1982, the program has gained national recognition in the field of treating impaired doctors. Dr. Canavan is a member of the Mercer County Medical Society and The Academy of Medicine.

### New health insurance for members

The Provident Insurance Company has announced its withdrawal as the MSNJ-endorsed health insurance plan effective June 30, 1996. The new carrier, Blue CrossBlue Shield of New Jersey, will offer a broad menu of plans with greater benefits and at lower rates. Please watch your FAX machine and mail for information, or call 1/800/682-7694.

(continued on page 63)



Vito M. Gulli, MD



Jeffrey S. Pollack, MD



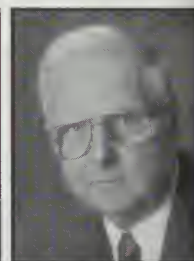
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*Health Care in the Garden State*

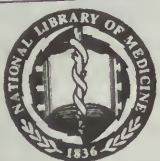
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Deficits in primary care have caused substantial numbers of unnecessary hospital admissions for New Jersey children aged 0 to 4 years, according to data recently released by a local health planning board. Especially high rates of hospitalization were noted for gastroenteritis, bacterial pneumonia, and severe ear-nose-throat infection, concluded the Mid-state Health Advisory Corporation, which administers Local Advisory Board (LAB) IV.

The study focused on **ambulatory-care sensitive (ACS) admissions**, which are used as a population-based indicator of insufficient primary care. The theory is that over a large enough population to make differences statistically significant, communities that show high hospital admission rates for ACS conditions are experiencing a problem in obtaining sufficient access to high-quality primary care providers.

Among age groups other than young children, reported LAB IV, asthma was the ACS condition with the highest rates of hospitalization. Using small-area analysis, researchers went on to find that some zip code areas in the three cities within the study area—**Trenton, Plainfield, and New Brunswick**—had consistently high ACS rates. **Somerset County** and **Hunterdon County** children had consistently low rates.

The study was reported in the spring 1996 issue of *Updates*, the newsletter of the Central New Jersey Maternal & Child Health Consortium, Inc.

**Perhaps 1 in 20 New Jerseyans would benefit from cardiac rehabilitation, yet is not receiving car-**

**diac rehabilitation services. This estimate is a crude extrapolation of data highlighted by the federal Agency for Health Care Policy & Research, which has issued cardiac rehabilitation guidelines for use by patients and clinicians.**

Exercise training, education, counseling, and behavioral interventions are included in rehabilitation regimens. Cardiovascular disease still causes a majority of all deaths in the United States. **Nanette Kass Wenger, MD**, of Emory University School of Medicine and **Erika Sivarajan Froelicher, RN, PhD**, of the University of California-San Francisco (UCSF) School of Medicine chaired the study panel.

**A national newsletter on medical malpractice, *Medical Liability Monitor*, has showcased the Medical Inter-Insurance Exchange (MIIX), located in New Jersey, which plans to extend its operations into 19 states.**

As a vehicle for expansion, MIIX has purchased the Home Guaranty Insurance Company. MIIX also acquired CDC Associates, Inc., of Blue Bell, Pennsylvania, which has been renamed MIIX Capital Management and provides investment consulting services to physicians. MIIX also has been approved for membership in the Federal Home Loan Bank of New York to facilitate access to low-cost liquidity and letter-of-credit fees. A.M. Best has upgraded MIIX's rating from A- to A.

**Princeton University economist Uwe E. Reinhardt, PhD, who was interviewed by Steve Adubato in this magazine in April, has lashed out at the nationwide, managed care-driven strategy of controlling**



**costs by reducing hospital admissions. Writing in the summer issue of *Health Affairs*, Professor Reinhardt labels as a "perverse form of pricing" the use of flat per diem rates for hospitals.**

By forcing hospitals to load all their overhead costs into the first few days of a hospital stay, says Dr. Reinhardt, managed care organizations and other third-party payers are depriving patients of cost-effective, appropriate convalescent care in hospitals. "As the United States was busily emptying its hospital beds in the name of cost control," comments the famously witty health policy analyst, "total national health spending actually shot up from 8.9 percent of gross domestic product in 1980 to more than 13.6 percent in 1993. As track records go, this one is truly remarkable."

Besides the Reinhardt piece, the *Health Affairs* quarterly also reported on consumer surveys of health care trends, the transition to competition, and cost control under managed care.

Consumer surveys conducted last year under the Health Tracking and Community Snapshots initiatives of **The Robert Wood Johnson Foundation (RWJF)** presented apparently conflicting findings. Respondents reported greater success regarding access to care and quality of care within the previous three years, and they expressed confidence about the trend toward managed care, but they tended to believe that the system is getting worse rather than better. Limits on health insurance coverage dominated consumers' reported concerns.

Specifically, the article on surveys found the greatest concerns among Medicare beneficiaries and persons with health problems. Medicaid recipients actually reported improvements. The two

Northeast communities among the 15 studied were Boston and Wilmington, Delaware. Senior author of the piece was **James R. Knickman, PhD.**

Further reporting on the RWJF initiatives, economist **Robert Miller** of UCSF offers that the "good news is that competition is taking place" and is holding down the cost of health insurance premiums. "The bad news," says Professor Miller, "is the lack of competition based on measured and reported aspects of quality of care."

In an article aggressively titled, "Can Managed Care Plans Control Health Care Costs?" researchers **Jack Zwanziger** and **Glenn A. Melnick** cite the New Jersey experience with hospital rate setting as proof that competition works better than regulation at controlling health care costs. From 1980 to 1991, the researchers relate, health care costs rose 86 percent in the state and only 63 percent nationwide.

Yet, Professors Zwanziger and Melnick are guarded in their optimism. "It is still unclear," they contend, "whether the health care system, as restructured to control costs, will be able to provide acceptable access and quality. One critical requirement for the continuation of high-quality care is that physicians be integrated into the functioning of managed care plans."

Emphasizing the current preoccupation with costs, the Zwanziger-Melnick team cite a study of Minnesota state employees' purchasing behavior, in which a 1 percent rise in out-of-pocket premium costs resulted in an 8.6 percent loss of market share for the insurer. Of course, in the Northeast, we care more for quality and don't just buy what's cheap.

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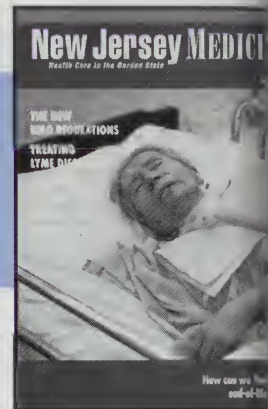
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New Jersey health care professionals need to create protocols for end-of-life care. This photograph was taken at The Millhouse, Trenton, which received the 1996 "deficiency-free" rating from the New Jersey Department of Health.



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# New Jersey MEDICINE

## *Anti-arthropod advice*

There is great concern regarding prevention and early identification of tick bites in areas where Lyme disease is prevalent.

The optimal approach involves the avoidance of tick bites, through means of physical protective measures and repellents applied either to clothing or directly to the skin.

Detaching ticks once they have succeeded in biting the host is not an easy task. These arthropods are uniquely designed for rapid penetration of the skin and firm attachment. At the site chosen for feeding, the tick will anchor to the host using the chelicerae and hypostome, the two main components of its feeding apparatus, cutting into the skin to seek out the capillary blood supply. A cement-like substance then is secreted that secures the tick to the host skin (Obenchain FD, Galun R: *Physiology of Ticks*. Oxford, England, Pergamon, 1982). Due to its firm attachment, removal of the tick is a difficult and often painful experience. Because damaging the tick may facilitate transmission of infected fluids into the host, it is recommended that ticks be removed with tweezers or curved forceps applied as

close to the skin as possible, followed by a steady upward pull, without twisting or crushing the tick (Needham GR: Evaluation of five popular methods for tick removal. *Pediatrics* 75:997-1002, 1985).

In an attempt to minimize the discomfort of the procedure, we began applying ethyl chloride to the site prior to removing the tick. In each instance in which we have used this technique, whether the host be human or animal, and regardless of the duration of attachment, we have observed that the tick is easily detached from the host.

Ethyl chloride, or chloroethane, is a flammable, high volatile gas that remains in liquid phase under increased pressure and vaporizes immediately on release. It is used as a topical refrigerant to control pain associated with minor surgical procedures, injuries, injections, and local myofascial symptoms. In addition to its anesthetic properties, it also is a solvent.

Whether its mechanism of action in the removal of ticks is by means of dissolving the cement-like secretions, anesthetizing the tick so that motor control is lost and mouth parts relax, or simply by freezing

the tick solid, remains to be investigated.

A note of caution should others adopt this same technique: ticks do not die unless literally drowned in ethyl chloride. They generally will thaw out and are able to resume their mission of seeking out new hosts. Proper disposal of the tick remains a major concern.

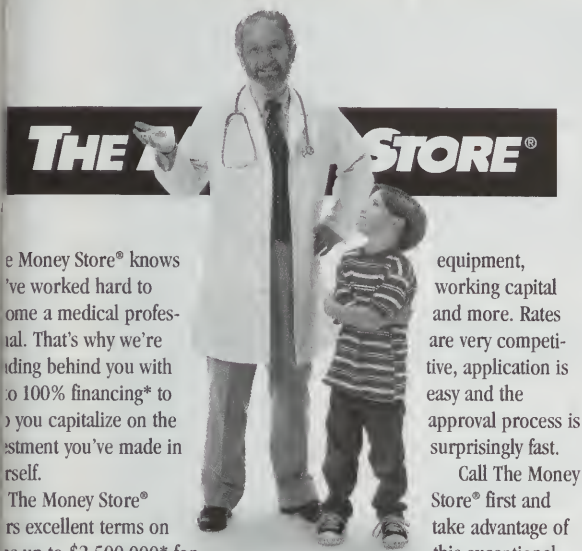
Elliot D. Rosenstein, MD  
Laura J. Kushner, DDS

## *Viral diagnostics activity*

This letter continues our tradition of sharing with the physicians of New Jersey, viral diagnostic activities of the UMDNJ-Robert Wood Johnson Medical School Viral Diagnostic Laboratory in New Brunswick. Although herpes simplex virus continues to be the most frequently isolated pathogen, the absolute number dropped from 211 to 160, accounting for about 30 percent of the total isolate. In calendar year 1995, we processed slightly over 2,000 specimens with an isolation rate close to 25.5 percent. The second most common virus isolated in 1995 again was respiratory syncytial virus (RSV) and accounted for 27 percent of the isolates.

*continued on page 10*

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continued from page 8

The RSV season was prolonged and severe in New Jersey. CMV again was the third most commonly isolated virus, accounting for approximately 24 percent of the isolates. For a third year in a row in 1995, there were more adenovirus isolates than usual, accounting for 5 percent of the total isolates. The entero viral isolation rate was about normal at 5 percent as well. The rotavirus isolation rate was slightly lower than usual at 4 percent of the isolates. Influenza isolates in 1995 were at an 11-year high at 3 percent. Paraflo and varicella zoster isolates made up the remainder of the 2 percent of isolates with rhinovirus isolation being accomplished for the first time in 1995. SMV PCR methodologies were added on a research basis in 1995. Economic pressures, as expected, forced the laboratory to reduce its staff by one half-time technician. The isolation results from our laboratory continue to be utilized by the New Jersey state Department of Health, Division of Epidemiology for their analysis of disease incidence in the state.

On a personal note, as I leave the state of New Jersey, it is my hope that this viral diagnostic laboratory will per-

severe under its new laboratory director, Frezoni Sebah, PhD. There is no question that the existence of a viral diagnostic laboratory is important to high quality in 1996 and the years beyond.

Lawrence D. Frenkel, MD

### **Metastases from metastasis**

I read with interest the article published by Langenfeld entitled, "Metastases from metastasis: A careful examination" published in the May 1996 edition of *New Jersey MEDICINE*. The authors state that clinical studies of this issue have been limited to autopsy reviews. I call their attention to an article that my colleagues and I published concerning metastases from metastasis of colorectal cancer in the liver

(August DA, Sugarbaker PH, Schneider PD: Lymphatic dissemination of hepatic metastases: Implications for the followup and treatment of patients with colorectal cancer. *Cancer* 55:1490-1494, 1985). In this article, we discussed a series of seven patients who were evaluated for surgical resection of liver metastases who had extra hepatic lymphatic disease limited to nodes draining the liver, implicating lymphatic dissemination from hepatic metastases as the mechanism of tumor spread. Four of these patients had node negative primary colorectal cancers.

The data presented in that paper support the conclusion of Langenfeld that metastases can indeed arise from earlier generation metastasis.

David A. August, MD

**NJM**

### **Requirements for letters**

To submit a letter, FAX (609/896-1368) or mail a copy of your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

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## TWIN awards

**Mary B. Todd, DO, Georgia Nadler, RN, BSN, MBA, Jane Rodney, and Carol Laws-Krause, RN,** were among those honored with the TWIN Awards by the Princeton YWCA at ceremonies in Princeton. The TWIN Awards recognize the outstanding achievements of women who have made significant contributions to their company and to the community. Dr. Todd is deputy director of the Cancer Institute of New Jersey, and a member of MSNJ and of the Middlesex County Medical Society. Ms. Nadler is vice-president of patient services at The Medical Center at Princeton. Ms. Rodney is director of the Breast Cancer Resource Center at the Princeton YWCA. Ms. Laws-Krause is a diabetes support specialist at Novo Nordisk Pharmaceuticals, Inc.

## NJHA update

**George F. Lynn, president and CEO of AtlantiCare Health System, has been named chair of the New Jersey Hospital Association (NJHA) Board of Trustees.** NJHA, formed in 1918, represents 114 hospitals throughout the Garden State. Previously, Mr. Lynn was president and CEO of Atlantic City Medical Center and executive vice-president and CEO of West Jersey Health System.

In addition, NJHA honored **Michael W. Azzara and James M. Oleske, MD, MPH.** Mr. Azzara received the NJHA Distinguished Service Award for his long-



George F. Lynn

## New medical directors

Kennedy Memorial Hospital-University Medical Center, Stratford appointed **Christopher J. Barone, DO,** assistant vice-president/divisional medical director, responsible for coordinating the medical affairs. Dr. Barone will serve as director of medical education.



Dr. Barone

**Daniel Lee Herriman, MD, JD,** has been named assistant vice-president/divisional medical director at Kennedy Memorial Hospital-University Medical Center, Cherry Hill and Washington Township divisions. He also will serve as director of outcome management.



Dr. Herriman

**standing commitment to NJHA. Mr. Azzara is chair of the Board of Health Research and Education Trust (HRET) of New Jersey; chair of the HRET Executive Committee; and president of The Valley Hospital in Ridgewood. Dr. Oleske received the NJHA Special Recognition Award. One of the nation's foremost pediatric AIDS specialists, Dr. Oleske serves as professor of pediatrics and director of Division of Allergy, Immunology, and Infectious Diseases at UMDNJ, and medical director of Children's Hospital AIDS Program, in Newark.**

## Physicians and the media

Physicians who want to effectively communicate with and educate the lay public through the media will want to attend the **Writers' Symposium for Physicians,** on October 19, 1996. The event is co-sponsored by the

American Society of Journalists and Authors and Columbia-Presbyterian Medical Center.

For additional information, contact the American Society of Journalists and Authors, 1501 Broadway, Suite 302, New York, NY 10036, 212/997-0947, FAX 212/768-7414.

## On top at the Department of Health

Anne Weiss is the new senior assistant commissioner in the newly designed New Jersey state Department of Health and Senior Services. Ms. Weiss will be responsible for health care regulation.



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### Do not go gentle into that good night

The critique of The Robert Wood Johnson Foundation's report on the care of the severely ill hospitalized patient by eminent attorney and ethicist, Paul W. Armstrong, is both sobering and disappointing.

To recap some of his salient points: one-half of American deaths occur in hospitals; dying patients received inappropriate care in inappropriate venues and too many received inadequate palliation; and efforts to improve the results by intensive education and communication failed to elicit any appreciable improvement.

A statewide summit proposed for later this year seems both timely and necessary.

My own interest and involvement in medical ethics parallels the efforts of MSNJ and its Committee on Bio-medical Ethics, outlined by its chairman, Joseph Fennelly, MD, in the coda to the Armstrong article. To cite from minutes of the Board of Trustees published in *The Journal of the Medical Society of New Jersey* (predecessor of *New Jersey MEDICINE*):

- January 16, 1983: "Dr. Slobodien suggested that the final report of the President's Commission on Medical Ethics be obtained for MSNJ."
- March 20, 1983: "Dr. Slobodien has made appointments to the Ad Hoc Committee on Women Membership and the Special Committee on Biomedical Ethics."
- April 29, 1983: "Dr. Slobodien noted that the Committee on Biomedical Ethics and

the Ad Hoc Committee on Women Membership were established."

And, as printed in the July 1983 transactions issue, my valedictory report to the House of Delegates said: "The brouhaha over the death penalty bill [in the summer of 1982] stimulated a broader interest in medical ethics; we expect much from the newly appointed blue-ribbon committee."

People, worldwide, are living longer and the advances in diagnosis, treatment, and technology that have helped to extend longevity also extend the hope of even greater survival in situations where their application is futile. But who is to judge the value of a life of limited duration and function? Who is to decide when enough is enough?

*The Journal of the American Medical Association (JAMA)* of August 12, 1988, devoted much

of that issue to medical ethics. Several of the articles warrant emphasis. Danis examined patient and family preferences for medical intensive care. Part of the results were: "Seventy percent of patients and families were 100 percent willing to undergo intensive care again to achieve even one month of survival; 8 percent were completely unwilling to undergo intensive care to achieve the prolongation of survival. Preferences were poorly correlated with functional status or quality of life . . . per-



Howard D. Slobodien, MD

*Who is to judge the value of a life of limited duration and function? Who decides when enough is enough?*



## EDITOR'S

### D E S K

*Dying is a troublesome business: there is pain to be suffered, and it wrings one's heart; but death is a splendid thing—a warfare accomplished, a beginning all over again, a triumph.*

George Bernard Shaw, in a letter of condolence, 1913

*It is not death, but dying, which is terrible.*

Henry Fielding, *Amelia*, 1751

sonal preferences may conflict with any health policy that limits the allocation on intensive care based on age, function, or quality of life."

In that same publication, Dr. Troyen A. Brennan reported the experience of the Optimum Care Committee (OCC) at Massachusetts General Hospital. He divided the types of problems encountered by the OCC into six groups:

- Type 1. A competent patient who wanted full treatment; the OCC agreed.
- Type 2. The treating physician refused to abide by OCC advice. (OCC did not dictate policy.)
- Type 3. OCC confirmed the decisions by both the family and the attending physician to withhold or remove treatment.
- Type 4. All three (family, physician, and OCC) agreed on DNR for an incompetent patient.
- Type 5. The physician and OCC wanted DNR; the family did not. This area is controversial from ethical, moral, and legal perspectives. Although the courts seem to prefer that these differences be settled outside the judicial system, there is variation from state to state.
- Type 6. OCC advice did not affect decision making.

Two editorials about the preceding, and other, articles also warrant our attention. The first, by Dr. Edmund D. Pellegrino, noted ethicist, states, "Medical ethics has become a public affair . . . every physician requires a more formal and systematic knowledge of ethical analysis and must know how to use the advice of ethics consultants wisely and well." He says, "Clinical ethics not only use deductive reasoning from principles to cases but resuscitates the casuistic method. . . . It seeks to find

out how best our moral maxims 'fit' in particular circumstances." He applauds the shift of ethics from the classroom to the bedside, where the hard decisions should preferably be made.

Nancy R. Zweibel, PhD, commenting on the Danis paper, focused on the circumstances in which patients and families would refuse treatment. She emphasized the need for studies to "determine where the threshold lies between an acceptable quality of life and an unacceptable quality of life that would cause patients to refuse life-extending treatment" and how the information "can be applied to the individual patient, for this is the level at which treatment decisions must be made."

The most recent opinion of the AMA's Council on Ethical and Judicial Affairs changes the social commitment of the physician from "prolonging" life to "sustaining" life, as well as relieving suffering. It also adds the phrase, "Where the performance of one duty conflicts with the other, the preferences of the patient should prevail." Additional details also were added regarding advance directives and circumstances under which treatment may or may not be given. However, these guidelines do not solve the problem of doing right by the individual patient.

One might expect that the application of one's own standard of care, what one might want personally, would suffice. In today's complex world, with the concomitant diversity of personal choices, that is not enough. I hope the planned summit will help us all in our approaches to this thorny problem. It must, of course, be part of an ongoing effort, even if it omits the equally troublesome aspects of managed care influences and assisted suicide.

**NJM**

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#### References:

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Bill Berlin, PhD

## INTERVIEW WITH MAUREEN LOPES

**Ms. Lopes resigned as senior vice-president, Health Affairs, New Jersey Business & Industry Association, to go sailing for two years.**

**Q.** Where do you think we're going with health care in the state? What are the key trends?

**A.** Certainly, New Jersey is going to follow what is happening in the rest of the country right now. We've been slow to get into managed care compared to California, Minnesota, and other states. So, we're playing catch-up. Partly what we're seeing is a backlash because we're doing it so quickly now in New Jersey. There will be lots of discussion about controls on managed care, how fast it's going to happen, what choices are left for people. But unless there is some other national movement that is going to control health care prices and deal with preventive medicine, I don't see that discussion making much difference. Corporations have really benefitted from managed care, so there will be a lot of pressure to keep this system.

**Q.** Do you think there are things we need to do to negotiate this transition period?

**A.** The state has been doing that. The New Jersey State Department of Health (DOH), through its HMO Advisory Committee, really did bring to the table all the major players. That model of how things could happen would be a great way to move forward in other areas, too. Everyone around the table said we also need to expand this level of regulation beyond HMOs to other managed care plans, like the preferred provider plans. So if there is reasonable oversight, and the commissioner of health takes that very seriously, that's what needs to be done.

**Q.** You mentioned the corporate impetus behind managed care. But don't we need to make a distinction between the interests of the large corporations and those of small business? Health care costs per capita for corporations have declined, but the national data indicate that premiums for small businesses rose by 6.5 percent in 1995.

**A.** In fact, NJBIA members are not telling us that. For

three years in a row now, NJBIA has done a health benefits survey of its members, and as of last fall those who had moved into an HMO or PPO actually were seeing no increase in premiums. Those small businesses that were holding on to the traditional fee-for-service plans were seeing a dramatic increase. But with the small group reforms, managed care now is available down to a group of two people, where it was not previously.

**Q.** What are you hearing from NJBIA members regarding health care? Is there more or less satisfaction now?

**A.** I think we're still in a transition period. A lot of small businesses are not used to the more competitive environment. Over the last two or three years, carriers have been forced to compete for that business. Employers had been used to a system where they would not dare change carriers, because they might face exclusions based upon pre-existing conditions, or that type of thing. Now, it's a different world. We tell our members that if they face a premium increase, they should go back to their carrier and try to negotiate, or they should look around for a better deal. You also have standard plans



out there now, so carriers can't play games about what they will provide. I think as employers catch on to this more competitive market, they will participate more, rather than feel victimized by it.

**Q.** You were involved with the Health Care Reform Coalition that worked on the uncompensated care issue back in 1993. What's your reaction now to the latest "solution"? Is it déjà vu all over again?

**A.** This actually is the fourth go-around on this issue, and there clearly are no easy answers. It's been very unfortunate, and the problem will be back two years from now. If the state does not want to take money out of the general coffers, they are going to continue to find some way to get into another tax stream. Looking back, we at NJBIA deeply regret signing on to the unemployment insurance (UI) diversion. Our expectations are that the UI fund never will grow very large again, because it's too big a pot of money and it's too attractive.

**Q.** What key things do you believe we still need to accomplish in respect to health care in the state?

**A.** It would be nice to deal with charity care and the gaps in insurance coverage in a more coherent way. You want to encourage employers to provide coverage as much as possible, but there always will be people between jobs, or employers who cannot afford

to provide coverage. This gap will rise and fall with levels of employment. We really backed the Health Access Program, which involved subsidies to low-income individuals to buy their own coverage. That got off to a good start, and now it's not going to be funded very much at all.

We also need to deal with the problems of the urban hospitals. Will they be part of networks and maintain a presence in those cities where



*Maureen Lopes*

they are often the largest employer, such as Paterson? And we need to address graduate medical education. How many specialists do we need? How many family physicians are needed? These questions are not being addressed adequately.

**Q.** You've said that the one constituency that has been left out of health care planning is the patients. If citizens are more involved, won't they also need to be better educated about health care?

**A.** You can see that educational process happening now to some extent. Both public and commercial television stations focus more on personal health now as do most newspapers. But I still find that most people do not take responsibility for their own health. They rely on experts and do not ask the right questions. That may be a very long-term cultural change that needs to occur.

**Q.** Do you find that the business sector is asking the right questions because they are more apt to be paying the bills?

**A.** Yes, the people who are paying the bills are asking more questions, but not necessarily the people, for whom they are paying. The larger corporations with full-time health benefits departments are spending a lot of time putting interactive medical programs on computers that can walk people through information and procedures about a health problem. I think the Internet can make a big difference in the next five to ten years. I've encouraged DOH to put general consumer information on a home page on the Internet. We know that certain patient groups, such as people with AIDS, communicate with each other about new treatments on the Net. This could represent a big change in the next few years in how people get health information.

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# Improving end-of-life care for New Jerseyans

Paul W. Armstrong, Esq.

Mr. Armstrong was counsel to the Quinlan and Jobes families and to the American Hospital Association as amicus curiae for the Cruzan case and is chair of New Jersey Health Decisions.

The medical community always has welcomed critical examination of its methods in the belief that the sum of knowledge will improve with disciplined challenge of traditional assumptions. To this end, health care professionals and others have studied end-of-life care, in an effort to create protocols for treatment.

The Robert Wood Johnson Foundation, one of New Jersey's most prominent residents and the nation's largest philanthropy dedicated to health care issues, recently issued the results of its comprehensive Study To Understand Prognosis and Preferences for Outcomes and Risks of Treatment (SUPPORT). The results were reported in JAMA (November 22, 1995) in the article, "A Controlled Trial To Improve Care for Seriously Ill

Hospitalized Patients." This significant and troubling investigation of dying and death in American hospitals raises important medical and ethical questions about pain control, fundamental communication, and patient preferences.

The readers of *New Jersey MEDICINE* are the primary architects of the protocols sur-



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Paul W. Armstrong, Esq.

rounding the dying process in our state's hospitals and have much to learn from the SUPPORT study's conclusions.

Accepting that one-half of all American deaths occur in hospitals, The Robert Wood Johnson Foundation commenced extensive research, in 1989, into the

character of dying in the hospital milieu. The four-year study, funded by multimillion-dollar grants, enlisted five teaching hospitals and over 9,000 patients with life-threatening maladies.

The first two-year phase of the project sought to discern the actuality of hospital dying and the second two years employed an intervention crafted to address the specific problems discovered in the initial phase. The alarming outcome of the examination was the utter unsuccessfulness of the intervention's efforts to alter the negative characteristics of hospital deaths.

The first 24 months of the study were devoted to collecting and examining data concerning the actual care hospitals provided to seriously ill patients at a high risk of dying. English-speaking adult patients with severe illness and with a 50 percent chance of dying within six months qualified for the study. Medical conditions were varied and approximately one-half of the study's patients died within the six-month period—a majori-





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*The ethical issues at the beginning and end of life are complex.*

ty of these deaths occurred in the hospital. Patient, physician, family, and surrogate interviews and concurrent and retrospective medical record reviews provided the source of collected data.

The criteria informing and authenticating the quality of the patient's hospital experience yielded five objective categories: the existence of a patient's written do-not-resuscitate (DNR) order and the time of its entry into the chart; the physician's knowledge of the patient's DNR order; the number of undesirable days a patient spent before death in the intensive care unit (ICU), on a ventilator or in a coma; patient pain levels; and institutional resources expended on the patient.

The phase one researchers startlingly documented that the fundamental experience of hospital patients reflected many shortcomings in care. For example, families shared that one-half of patients able to communicate spent most of their last few days in moderate or severe pain. Nearly one-half of all DNR orders were written in the last two days of life. Less than one-half of the physicians of patients who chose not to be resuscitated understood their choice and the final hospitalization for one-half of the study's patients included more than eight days in generally undesirable states: in an ICU, receiving mechanical intervention, or comatose.

The three-pronged strategy of the second phase of the SUPPORT study sought to design, deploy, and weigh an effective intervention that would foster critical communication among patients, physicians, and surrogates. An elegant effort commenced to improve decision making by providing timely and reliable prognostic data, by eliciting and document-

ing patient preferences and understanding of prognosis and treatment, and by providing a skilled nurse to effect the needed discussions, convene meetings, and disseminate relevant information. Approximately 2,500 patients participated in the special protocol and an equal number of similarly ill patients were assigned to only usual medical care.

As with phase one, the results of phase two are equally sobering. The five critical categories, despite often Herculean efforts, remained unaltered. No appreciable changes in prevalence of pain, resources consumed, "undesirable days," DNR timing, or agreement anent DNR between doctor and patient were realized. A serious and costly American experiment failed to change the shortcomings in contemporary hospital patient care.

*The investigation of dying and death in American hospitals raises important medical and ethical questions about pain control, fundamental communication, and patient preferences.*

The SUPPORT study gives a unique empirical snapshot of how the modern acute care setting fails to take seriously the preferences of the seriously ill. While courts and legislatures nationwide have enunciated and embraced the fundamental right of all to make medical decisions at the end of life, the community of medicine has yet to develop protocols and procedures that recognize and implement the exercise of these profound choices. Despite an overwhelming public consensus on patient autonomy, the physician-patient relationship and the doctrine of informed consent have failed to provide the traditional haven for humane counsel and acts that have defined the healing arts since time out of memory.

Those at the helm of hospitals are equally disquieted by the failure of a refined intervention to ameliorate the exposed institutional deficiencies that ignore their patients' preferences. The overall impact of end-of-life decisions that seem to defy common sense and compassion remains an open question for responsible caregivers in an era marked by faltering efforts to define and achieve the goal of managed care for all.

There can be little doubt about the large service The Robert Wood Johnson Foundation study has provided. The SUPPORT findings challenge the New Jersey health care community to recognize that collective efforts to improve end-of-life care are critical and worthy of our immediate attention.

In this spirit, MSNJ and New Jersey Health Decisions will convene a statewide summit this fall, to address the rights, duties, responsibilities, and obligations of physicians, patients, families, caregivers, and society in the humane enterprise of caring for the dying. The summit's theme and task will include an exploration of SUPPORT conclusions and their application to New Jersey as well as an objective dialogue about the proper role of medicine in the reform of protocols surrounding end-of-life decisions.



### MSNJ Committee on Biomedical Ethics

The first MSNJ Committee on Biomedical Ethics meeting took place on October 12, 1983. The formation of the Committee on Biomedical Ethics grew out of the reaction to a court decision in state Board of Medical Examiners v. Greco. In this case, the judge determined that the doctor was guilty of gross neglect by failing to admit two terminally ill patients to the hospital for aggressive care. The judge concluded that there existed a "treatment imperative," stating that a concept of the "right to die" requires a formal act on the patient's part to make intentions known.

In testifying for Dr. Greco, Dr. David Eckstein, a compassionate geriatrician and first chair of the Committee on Biomedical Ethics, disagreed with the court's conclusions that: "Doctors frequently make unilateral decisions to withhold aggressive treatments from incompetent nursing home persons dying of disease," and hospice care presently is provided [only] at designated centers specifically recognized "and not in long-term facilities." In Dr. Eckstein's opinion, these conclusions were unsubstantiated and counter to the philosophy of long-term treatment of terminal cases.

The initial charge to the Committee on Biomedical Ethics was "to bring an ethical analysis of the practice of medicine to issues confronting physicians and patients through the process of birth, life, and death; to help clarify the issues and highlight the facts that are most relevant for decision making; to offer guidance to people involved in making decisions though not dictate particular choices; and to balance the advances of science and technology with the realization that life has a conclusion and the patient a right to his dignity."<sup>1</sup>

The first Committee on Biomedical Ethics project was to develop a model long-term care "supportive care plan," building on the Quinlan court's suggestion of institutional ethics committees.<sup>2</sup>



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This concept was approved by MSNJ in 1984. However, in 1985, in the matter of Clair Conroy, required that the state ombudsman for the institutionalized elderly be included in the decision-making process concerning terminally ill nursing home patients. This insertion slowed down adaptation of supportive care guidelines.

The Committee on Biomedical Ethics maintained working relationships with all representatives of the health care community including citizens groups and the state bioethics commission. This created a forum through which a continuum of ideas and ideals would exist.

The educational activities of the Committee on Biomedical Ethics include presentations in conjunction with The Academy of Medicine of New Jersey at the last three MSNJ annual meetings; a well-known play on advance directives; and programs on guidelines about medically futile therapy- and patient-centered medical ethics. In addition, many members contributed to the *New Jersey MEDICINE* special issue on biomedical ethics in 1989.

As ethical issues at the beginning and end of life, such as genetic engineering, surrogacy, and the role of high technology out of hospitals, become more complex, the activities of the Committee on Biomedical Ethics included developing a shortened version of the inclusive bioethics commission's advance directive; influencing the MSNJ Board of Trustees to bring court action in relationship to the state Board of Medical Examiners interpretation of "Farrell" guidelines as applied to in-hospital DNR guidelines; developing guidelines for the MSNJ Board of Trustees for resolving conflict in issues surrounding medically futile therapy; and recom-

mendations for ethical standards for managed care business.

What of the future? From time out of memory, the "healer" has been aware of the vulnerability and the child-like dependency of a sick person on the physician, as well as the obligations for physicians to honor the quality of the patient's life and to acknowledge the reality of death. The bedrock of these actions is the centrality of a trusting patient-doctor relationship. We must lead in creating and protecting what the late philosopher, Hans Jonas, calls an ethic of responsibility. The issues of cost-driven health care and physician-assisted suicide are societal issues that threaten to erode the sacred doctor-patient relationship. The Committee on Biomedical Ethics is committed to preventing this erosion by confronting these issues and will accept the responsibilities to protect the practice of the art and of the science.

The Committee on Biomedical Ethics is determined to respond to the Chinese proverb of change as crisis, creating through imagination and dedication, the opportunity for the Committee on Biomedical Ethics to redirect the moral compass as we help steer society through the sea of changes around us.

*Joseph Fennelly, MD*

*Chair, Committee on Biomedical Ethics*

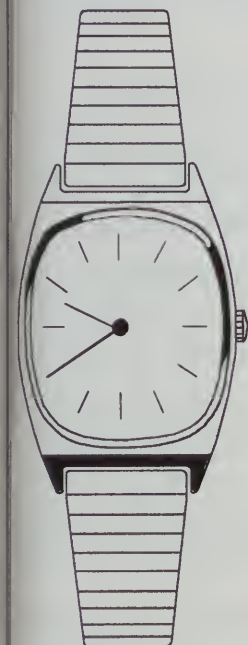
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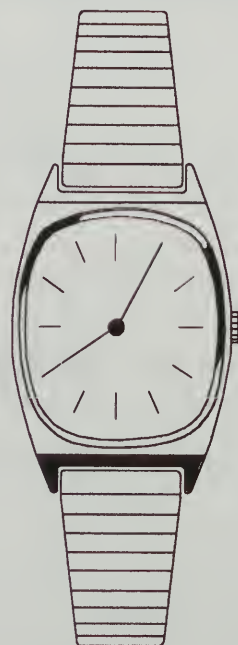
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## TRENDS IN BREAST CANCER DIAGNOSIS AND TREATMENT

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The authors are affiliated with Saint Barnabas Medical Center, where Dr. Sanfilippo is chair, Department of Radiation Oncology, Mrs. Duncan is director, Cancer Registry, and Dr. Zablow is affiliated with the Department of Radiation Oncology.

In the United States, breast cancer is the most commonly diagnosed female malignancy and second to lung cancer as the leading cause of death by cancer. The American Cancer Society estimated that in 1995, 182,000 women were diagnosed with breast cancer and 46,000 died from the ravages of the disease.<sup>1</sup>

From 1970 to 1994, 6,042 analytic cases of breast cancer were treated at Saint Barnabas Medical Center (SBMC). These cases were abstracted into the cancer registry and form the basis of this report. This analysis examines the trends in breast cancer diagnosis at SBMC and compares treatment and outcomes data with national statistics.

Six aspects were identified and analyzed: incidence of breast cancer at SBMC compared with national rates; change in stage at initial presentation between 1978 and 1992 data; change in age of women presenting with breast cancer from 1978 to 1992; location of cancer within the breast; treatment for breast cancer compared with national data; and survival rates from 1985 data compared with national survival rates.

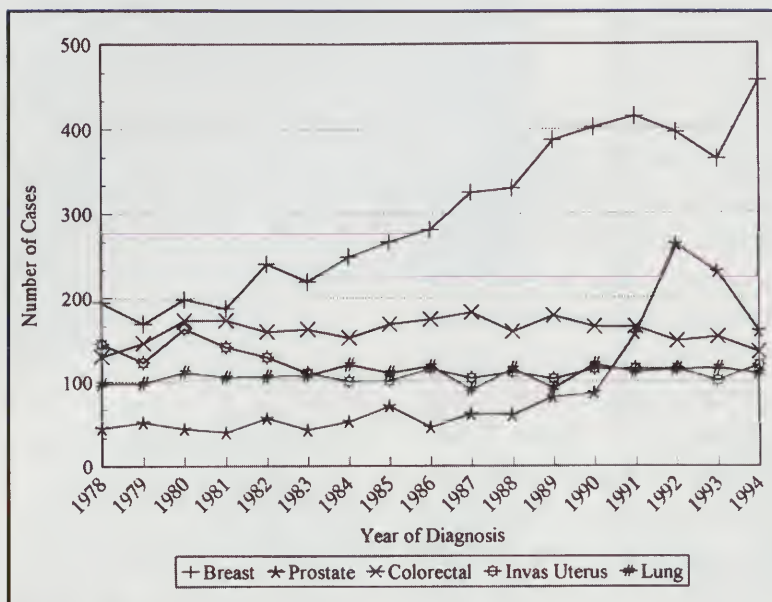
**Methods.** All patients admitted to SBMC diagnosed and/or treated for a known cancer are abstracted into the cancer registry. All cases are categorized as either analytic or non-analytic. Analytic cases are patients who are first diagnosed and/or had part of the first course of treatment administered at SBMC. Non-analytic cases include those patients who were first diagnosed and had all of the first course of therapy administered elsewhere, cases first diagnosed at autopsy, and specific reportable benign cases that are part of the SBMC Cancer Committee's approved reportable list. All

analytic cases at SBMC are followed on an annual basis until death to obtain information on recurrences, subsequent treatment, second primaries, and cause of death. We included only analytic patients in this report.

The national statistics used in this paper are from the National Cancer Data Base (NCDB), a joint project of the Commission on Cancer of the American College of Surgeons (ACS) and the American Cancer Society. NCDB is a mechanism for periodic assessment of cancer patient care and its goal is to "provide a scientific resource suitable for assessing cancer patient care and outcome on a national basis and disseminate such information to the medical community."<sup>2</sup> The 1985 national data were obtained from NCDB's voluntary *First Call for Data*,<sup>2</sup> while the 1991 data were from the *Third Call for Data* accounting for an estimated 26 percent of all hospital-based incident cancers in the United States. The results were published in the *National Cancer Data Base: Annual Review of Patient Care*



*Diagnosis and treatment of breast cancer has undergone significant changes in the past 25 years. Last year, 182,000 women in the United States were diagnosed with breast cancer.*



**Figure 1.** Major cancer sites of patients from Saint Barnabas Medical Center.

1993.<sup>2</sup> The 1991 national data were obtained from NCDB's *Third Call for Data*.<sup>3</sup> The 1985 and 1991 national data accounted for an estimated 26 percent and 46 percent of all hospital-based incident cancers in the United States, respectively. SBMC has been contributing data annually to NCDB since 1993.

### Results and discussion.

**Incidence of breast cancer.** The number of breast cancer patients at SBMC has steadily increased from 89 in 1970 to a peak in 1994 of 454 analytic cases. Figure 1 charts the major cancer sites at SBMC in

1994 and their trends in incident cases for each of these sites since 1980. Breast cancer continues to be the most common site of cancer, accounting for 23 percent of all analytic

cases in 1985 and 24 percent of analytic cases in 1992. National data revealed incidence rates of 15 percent and 15.2 percent, respectively. The incidence of breast cancer was 53 percent and 58 percent higher at SBMC for the years 1985 and 1992, respectively. Figure 2 shows the number of analytic breast cancer cases at SBMC from 1970 to 1994. Our figures, 35 percent in 1985 and 40 percent in 1992, are higher than the national rates of 29 percent and 32 percent of all female cancers diagnosed in 1985 and 1991, respectively.

**Stage of breast cancer at presentation.** Beginning in 1981, all analytic breast cancer cases have been staged by the cancer registry using the

**Table 1. Stage of breast cancer.**

TNM stage	SBMC		NCDB	
	1985	1992	1985	1991
0	9%	17%	6%	12%
I	35%	41%	36%	41%
II	36%	31%	40%	34%
III	16%	5%	12%	8%
IV	4%	6%	6%	5%

SBMC = Saint Barnabas Medical Center  
NCDB = National Cancer Data Base

*In addition to improved therapy, early detection plays a major role in reducing morbidity and mortality associated with breast cancer. The best screening technique is mammography.*

**Table 2. First indication of breast cancer.**

Found by:	SBMC	
	1985	1992
Patient	62%	35%
Mammography	23%	45%
Physician	9%	5%
Other	4%	6%
Unknown	3%	8%

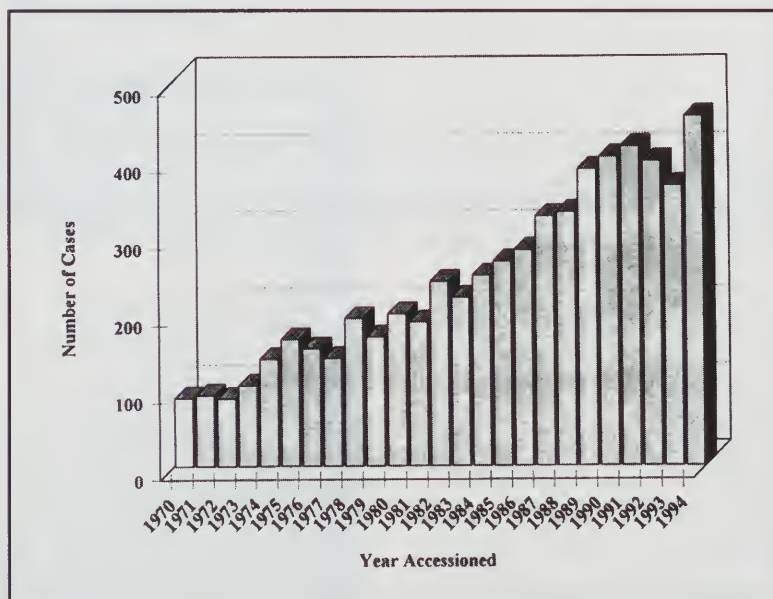
American Joint Committee on Cancer (AJCC) TNM Staging System.<sup>4,6</sup> The 1978 data, based on the SEER staging system, showed 7 percent in situ cancers. Forty-six percent had regional disease, which includes pathologic findings of skin invasion, peau d'orange, inflammatory cancer, chest wall muscle invasion, and/or axillary nodal involvement. An additional 40 percent had localized disease and 7 percent had distant metastases at time of diagnosis, the equivalent of AJCC Stage IV.

Table 1 shows the SBMC distribution of breast cancer by AJCC staging for 1985 and 1992 analytic cases compared with national data. At SBMC, we have seen a greater increase in earlier diagnosed cases compared to the national

average. This may be attributed to an increased level of education and public awareness in our hospital community, improved mammographic techniques and equipment, and the annual breast cancer screening

programs offered to the public since 1987. The increase of in situ lesions from 1985 to 1992 is due predominantly to the increased use of screening mammography and improved imaging.

Table 2 illustrates the first indication of breast cancer for SBMC patients in 1985 and 1992. In addition to improved therapy, early detection plays a major role in reducing the morbidity and mortality associated with breast cancer. The best screening technique available is mammography. The first definitive trial studying the effect of mammography screening on breast cancer mortality



**Figure 2.** Number of analytic breast cancer cases at Saint Barnabas Medical Center.



*The American Cancer Society recommends yearly examinations for women over 50 years of age and examinations every one to two years for women between 40 and 50 years of age.*

**Table 3. Age at diagnosis.**

Age in years	SBMC			NCDB	
	1978	1985	1992	1985	1991
<39	9%	7%	8%	8%	7%
40-49	16%	23%	30%	16%	18%
50-59	34%	23%	24%	21%	19%
60-69	22%	25%	18%	26%	25%
70-79	12%	17%	14%	20%	22%
>80	6%	5%	7%	9%	10%

was the Health Insurance Plan (HIP) trial. Participating patients were subjected to annual two-view industrial film mammography and physical examination. The study found a 30 percent reduction in mortality from breast cancer.<sup>7</sup>

A Swedish program was initiated to attempt to reproduce the findings of the HIP trial. Their initial findings published in 1985 found a 31 percent decrease in mortality in those women undergoing screening mammography. Their study was updated in 1992. With an average followup of 10.8 years, the decreased mortality remained exactly the same.<sup>8,9</sup> During the time period of the Swedish study, mammographic equipment and techniques had improved. Screen film mammography replaced industrial film proving more sensitive and

patient exposure to radiation was markedly reduced. This evidence indicates that mammographic screening for breast cancer helps to reduce the death rate.

The American Cancer Society recommends yearly exam-

inations for women older than 50 years of age and every one to two years for women between the age 40 and 50 years. Opponents feel that the examinations are of questionable value and cause increased patient anxiety concerning actual performance of the examinations and the findings. Proponents feel that increased education and monthly self-examinations, coupled with periodic professional examinations, will contribute to decreased mortality.

*Age of breast cancer patients.* National data indicate breast cancer is a disease primarily afflicting older patients, with approximately 75

**Table 4. Location of cancer.**

Site	SBMC		NCDB	
	1985	1992	1985	1991
UIQ	7%	13%	9%	8%
LIQ	7%	8%	4%	5%
UOQ	36%	41%	36%	36%
LOQ	9%	8%	7%	6%
Axillary Tail	2%	1%	7%	1%
Central	13%	10%	6%	7%
Overlap	14%	13%	17%	19%
NOS	12%	6%	21%	18%

UIQ = Upper inner quadrant SBMC = Saint Barnabas Medical Center  
 LIQ = Lower inner quadrant NCDB = National Cancer Data Base  
 UOQ = Upper outer quadrant  
 LOQ = Lower outer quadrant

*The surgical management of breast cancer has dramatically changed over the past 15 years. Mastectomy had been the gold standard of treatment until the late 1970s and the early 1980s.*

percent of patients presenting over 50 years of age (Table 3). National data from 1985 revealed 24 percent and 45 percent of breast cancers were diagnosed in women less than 50 and 60 years of age, respectively. Interestingly, 1991 almost was identical, with 25 percent and 44 percent, respectively. No trends over time were evident in the national data regarding age at diagnosis. SBMC data revealed a younger age distribution in women presenting with breast cancer.

*Location of tumor within the breast.* Table 4 shows the location of the tumor within the subsites of the female breast. There was no apparent difference in location of tumors between 1985 and 1992. The most common site, the upper outer quadrant of the breast, accounted for 41 percent of cases in 1992 and 36 percent in 1985. This was comparable with the national data, 36 percent in 1991 and 1985. The number of SBMC cases with subsite unknown decreased from 12 percent in 1985 to 6 percent in 1992. These cases predominantly were referred from outside institutions for adjuvant treatment lacking

**Table 5. Type of surgery.**

Stage	All stages				
	SBMC			NCDB	
	1978	1985	1992	1985	1991
<b>Partial Mastectomy</b>	6%	47%	53%	19%	36%
<b>Total Mastectomy</b>	5%	2%	3%	4%	4%
<b>MRM</b>	68%	48%	42%	67%	53%
<b>Radical Mastectomy</b>	10%	—	—	—	—
<b>Other/None</b>	11%	3%	2%	10%	8%

Stage	Stages 0 and I				
	SBMC			NCDB	
	1978	1985	1992	1985	1991
<b>Partial Mastectomy</b>	4%	60%	62%	26%	45%
<b>Total Mastectomy</b>	8%	1%	3%	—	—
<b>MRM</b>	76%	37%	35%	—	44%
<b>Radical Mastectomy</b>	8%	—	—	—	—
<b>Other</b>	4%	2%	0%	74%	11%

detailed pathological and surgical information.

*Treatment for breast cancer at SBMC.* The surgical management of breast cancer has dramatically changed over the past 15 years. Mastectomy had been the gold standard of treatment until the late 1970s and early 1980s. The radical mastectomy, widely popular-

ized by Haagenson and the operation of choice for most of this century, slowly gave way to the less mutilating modified radical mastectomy. Clinical trials from the United States and Europe suggested that breast conserving surgery (BCS) and postoperative radiation therapy was an equally efficacious treatment for localized breast



*Adjusted survival rates for patients with breast cancer more accurately account for cancer as a cause of death for women, and are recommended for smaller sample sizes.*

**Table 6. Treatment regimens—all stages.**

Treatment	SBMC		NCDB	
	1978	1985	1992	1991
<b>Surgery</b>	37%	42%	45%	42%
<b>Surgery/RT</b>	29%	44%	23%	13%
<b>Surgery/RT/ chemotherapy</b>	13%	8%	22%	15%
<b>Surgery/ chemotherapy</b>	10%	3%	7%	24%
<b>Other</b>	11%	3%	3%	6%

cancer.<sup>10-12</sup> BCS has not been equally embraced throughout the country. Several reports have shown increased use of BCS during the last decade with wide geographic variances.<sup>2,13,14</sup>

NCDB data showed an increase in BCS from 1985 to 1991 (Table 5). In 1985, the rate of BCS for all stages of breast cancer was 19 percent with 71 percent of patients undergoing mastectomy. In 1986, Nutting examined the data of 37,000 women 65 to 79 years old and reported 12.1 percent had BCS and 87.9 percent had mastectomy.<sup>14</sup> In 1991, NCDB reported the rate of BCS had increased to 36 percent and mastectomies decreased to

57 percent with major geographic variations. Farrow reported BCS rates were ranging from 9.2 percent to 32.1 percent in 1983 to 1984 and from 19.6 percent to 41.5 percent in 1985 to 1986.<sup>13</sup> NCDB found the New England region to have the highest BCS rate (54.6 percent) and the east-south-central region to have the least (17.1 percent).<sup>2</sup> SBMC is located within the mid-Atlantic region, which had the second highest BCS rate (43.0 percent).

Table 5 also compares the percent of early stage breast cancers (Stage 0 and I) with the type of surgery performed.

Table 6 depicts the percentage of SBMC breast cancer patients by various treatment

modalities for all stages during the years 1978, 1985, and 1992. The most commonly utilized treatment in 1992 was surgery alone, followed by surgery and radiation. Twenty-two percent of patients received a combination of surgery, radiation, and chemotherapy (including hormones). These figures compare with 1991 national rates of 42 percent, 13 percent, and 15 percent, respectively.

**Survival rates.** The only means by which we could compare survival results was using relative survival analysis. All 1985 analytic cases were analyzed for survival outcome results. Our five-year survival rates for Stage 0 (n=25), Stage I (n=93), Stage II (n=95), Stage III (n=42), and Stage IV (n=11) are 100 percent, 100 percent, 80 percent, 62 percent, and 20 percent, respectively. The national relative survival rates were 100 percent, 82 percent, 73 percent, 55 percent, and 23 percent, respectively for the same stages. Our five-year survival rates for Stages I, II, and III were higher than those reported for national data (Figure 3).

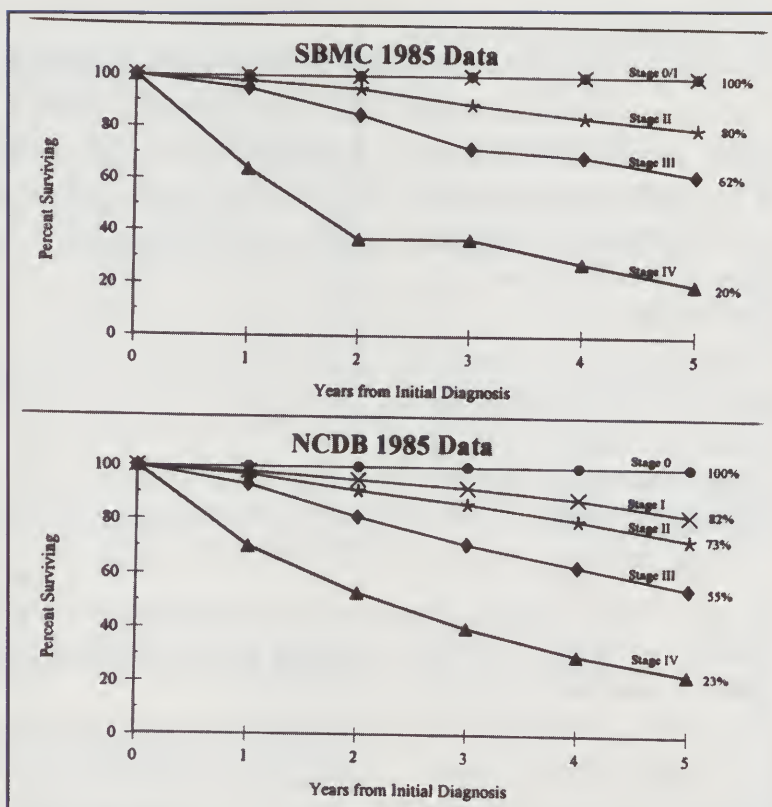
Adjusted survival rates more accurately account for cancer

## Improved outcomes and survival rates are the result of screening mammography, patient awareness, public education, and improved mammographic equipment and techniques.

as a cause of death, and are recommended for smaller sample sizes. SBMC figures were recalculated using the adjusted survival method with the following five-year rates: 100 percent for Stage 0, 98 percent for Stage I, 80 percent for Stage II, 61 percent for Stage III, and 18 percent for Stage IV. For all stages of disease, death was determined as directly/indirectly due to cancer or not related to cancer. This was confirmed by death certificates for all patients not expiring at SBMC. All 266 analytic 1985 breast cancer cases were followed for more than five years, and none was lost to followup during this time period.

Between 1981 and 1991, 2,929 patients were treated and available for survival analysis. The five- and ten-year adjusted survival rates were: 99.5 percent and 99.5 percent for Stage 0, 95.5 percent and 86.3 percent for Stage I, 81.3 percent and 70.9 percent for Stage II, 58.2 percent and 38.7 percent for Stage III, and 23.6 percent and 9.0 percent for Stage IV, respectively (Figure 4). These results were comparable to those of major centers.

SBMC continues to treat the largest number of breast cancer



**Figure 3.** Five-year survival rates at Saint Barnabas Medical Center compared to national statistics.

cases in New Jersey. From 1978 to 1992, we have seen an increased number of early stage cancers and younger women diagnosed with breast cancer. The number of breast conserving surgeries is higher than seen nationally. Our five-year survival rates were higher than national data. Factors such as screening mammography, patient awareness, public education, and improved mammographic equipment and techniques contribute to earlier diagnosis, which in turn trans-

lates into improved outcomes and survival rates.

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*All analytic cases at SBMC are followed on an annual basis until death to obtain information on recurrences, subsequent treatment, second primaries, and cause of death.*

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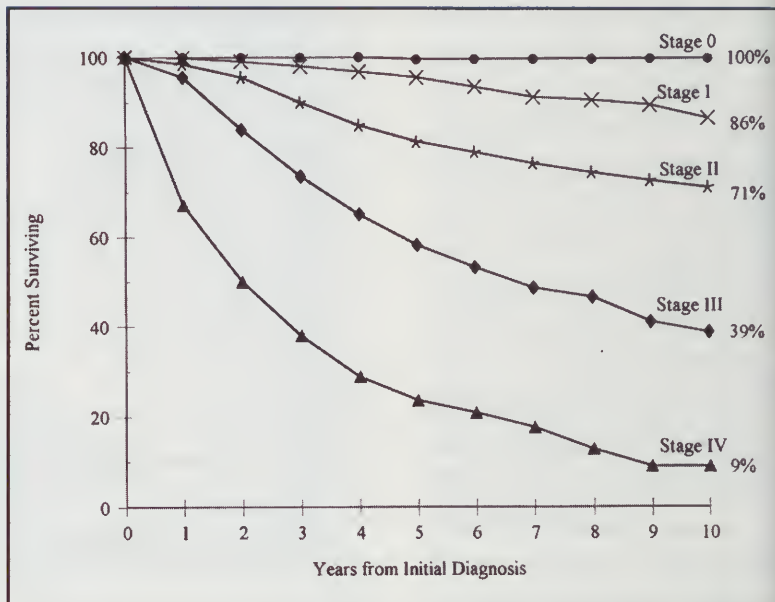
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**Figure 4.** Five- and ten-year adjusted survival rates between 1981 and 1991.

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# 1996 Person of the Year

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**NJM**

# PHEOCHROMOCYTOMA: ON THE VERGE OF EXTINCTION UNDER MANAGED CARE

*Joel S. Gross, MD  
Joshua R. Shua-Haim, MD*

**Drs. Gross and Shua-Haim are affiliated with Jersey Shore Medical Center, The Medical Center of Ocean County, and UMDNJ-Robert Wood Johnson Medical Center.**

Pheochromocytoma is a rare cause of hypertension. In autopsy studies in 1954, pheochromocytomas were found to account for 0.1 percent of all cases of diastolic hypertension.<sup>1</sup> Studies in the 1970s by Winkler and in the 1980s by Sutton indicated that the majority of such tumors are found unexpectedly at the autopsy table.<sup>2,3</sup> Because autopsy rates continue to decline, the true prevalence of this disorder may never be known.<sup>4</sup>

As HMO enrollment continues to rise,<sup>5</sup> the cost-saving approaches to health care may prevent the busy physician from diagnosing such a condition. We report a case of pheochromocytoma to alert physicians that such a condition should be considered in an older hypertensive patient not optimally

responsive to standard hypertension treatments.

**Case report.** A man of 65 years underwent a general evaluation. He had a history of hypertension since 1965, originally detected on a routine insurance physical examination. His father, mother, and sister also had hypertension. He felt well and had no headaches, palpitations, sweating, anxiety, or nervousness. Despite multiple medications over the past 30 years, his diastolic blood pressure had never been consistently below 90 mm Hg. He had period hypokalemia. Medications included hydralazine, hydrochlorothiazide, atenolol, lisinopril, and potassium chloride. His blood pressure was 180/96 and his pulse was 70. The blood pressure was equal in both arms. His lower extremity blood pressure was 15 mm greater than the upper. Fundiscopy showed grade II hypertensive retinopathy. Cardiac examination was normal. Abdominal examination revealed no bruits. Potassium was 3.2. Hyperaldostero-

nism was considered and a computed tomography scan of the abdomen was performed. The left adrenal gland showed a 2 cm mass suggesting a functioning adenoma or metastatic carcinoma. Serum renin was normal; urine VMA was 9.2 mg/24 hrs ( $n < 6.7$ ); urine metanephrine was 3476 mcg/24 hrs ( $n < 785$ ); plasma norepinephrine level was 1004 pg/ml ( $n < 410$ ); and plasma epinephrine level was 146 pg/ml ( $n < 50$ ). On magnetic resonance imaging, the left adrenal gland revealed marked uptake of gadolinium and confirmed a 2 cm mass. A metaiodobenzylguanidine (MIBG) scan was highly suggestive of pheochromocytoma involving the left adrenal gland.

On October 13, 1995, the patient underwent the successful removal of a 3 cm pheochromocytoma. He currently is maintained on nifedipine and terazosin with resulting normal blood pressure.

**Discussion.** Pheochromocytoma is an important cause



*Pheochromocytomas are one of the few potentially curable causes of hypertension. Under managed care, there may be less financial incentive to search for this elusive entity.*



© Beth Starkey

of hypertension and one that usually is curable when properly diagnosed and treated. The therapy for a pheochromocytoma is surgical removal as soon as possible. The need for such urgency is that if left unresected, a potentially life-threatening complication could occur.<sup>1</sup> A facility that has great experience in surgically removing this tumor is highly recommended.

What are the implications of this disease in the era of managed care? Managed care has produced significant cost reductions in the American health care system. HMOs will continue to pressure doctors and hospitals to reduce utilization of services by enrollees.

Lower physician incomes, increased hassles, and higher overhead expenses are making it increasingly difficult for the physician. The physician practicing in a managed care environment no longer may have the ability to consider such rare disorders such as a pheochromocytoma in their hypertensive patients.

The patient in this report incurred a total health care bill (including the office visits, testing, and surgical and hospital costs) of \$51,349.86. This patient was insured primarily by Medicare, in a traditional fee-for-service arrangement. As more Medicare recipients as well as younger patients enroll in managed care plans, the

diagnosis of this rare, yet curable, disorder will dwindle to nondetectable levels. With autopsy rates continuing to decline, the true prevalence of this condition may never be ascertained.<sup>4</sup>

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ADVANCES

# THE DEPARTMENT OF HEALTH AND HMO REGULATIONS

Commissioner Len Fishman

*Well-run HMOs can contain costs, coordinate care, provide preventive and primary care, and promote accountability through quality outcome measures.*

**Mr. Fishman is commissioner of health, New Jersey state Department of Health (DOH). He delivered these remarks at the Annual Meeting of the Medical Society of New Jersey.**

An annual meeting is a good time to reflect, renew ties, and chart the course for the year ahead.

And these are dizzying times for health care, with changes occurring almost daily. Just four years ago, our state, which had set hospital rates for more than a decade, let go of those regulatory reins, allowing for freer market competition.

We know we'll be seeing changes in Medicare and Medicaid at the national level, and, at the state level, we are witnessing the enrollment of 450,000 Medicaid beneficiaries in New Jersey HMOs.

We're seeing large integrated delivery systems, made up of several hospitals, nursing

homes and other health care facilities, and home health agencies—a spectrum of health care facilities and services. The newly formed Saint Barnabas Health Care System is the state's third largest employer, with 20,000 employees and annual revenue of \$1.5 billion.



Commissioner Fishman

Perhaps the most disturbing change is the rising number of uninsured. The number of people without insurance in New Jersey has nearly doubled from 590,000 in 1987 to 1.09 million in 1993.

There is some good news here. This upward trend was

interrupted in 1994 (the last year for which we have data) when the number of uninsured came down by 60,000. But there are still 1.03 million uninsured people in the state.

Rising health care and insurance costs led to an increase in the number of people without insurance. And it is employees' desire to control costs that is fueling the explosive growth of managed care.

HMOs in this state went from fewer than 5,000 members enrolled in 1975 to more than 1.5 million today. And as Medicaid recipients move to HMOs, the number is expected to top 2 million in the near future. HMOs and managed care organizations now represent about 35 to 40 percent of the insured in New Jersey.

These events are transforming your professional world. But physicians have the commitment that DOH will help assure it's not a world that frustrates your ability to do your best and what's best for your patients.



*For the first time, the Department of Health will establish and collect outcome measures—both population based and patient based—through the Health Data Committee (HeDaC).*

We've made good on that commitment through our newly reformed HMO regulations.

When I became commissioner of health, we had 20-year-old HMO regulations that were inadequate or silent on many issues that are important to you and your patients. So we overhauled those regulations, with three simple goals in mind:

- To protect consumers.
- To preserve the doctor-patient relationship.
- To allow HMOs to flourish.

You may feel that balancing these goals is tantamount to squaring the circle. I admit that at times it seemed like "Mission Impossible."

But a significant first step was achieved with the creation of the HMO Advisory Committee, a group made up of physicians and other health care providers, and representatives from HMOs, hospitals, consumer, business, and labor interests.

Thirty-two people met each month to analyze, debate, and recommend. It wasn't easy.

Remarkably, they were able to reach consensus on many of the important issues. And when they were not, the task fell to me.

After more than one and one-half years of work, we have what I believe are the most progressive, consumer-oriented regulations ever proposed in the country. It took a long time, but that's the price you pay for being inclusive—you get a better work product.

I believe HMOs can be a positive force in health care. Well-run HMOs can contain costs, coordinate care, provide preventive and primary care, and promote accountability through quality outcome measures. I also believe that as costs are contained, more people will join the ranks of the insured.

If HMOs are to be a positive force in health care—and just as important, if they are to be perceived as a positive force—we need to promote consumer protection and consumer confidence.

I want to thank a few people who were part of the HMO

Advisory Committee. Former MSNJ President Dr. Fred Palace and Dr. Patricia Klein were passionate, articulate advocates for patients and physicians. I also want to thank Neil Weisfield and Dr. Louis Keeler for their help, as well as MSNJ, whose policy paper, "Putting Patients First," helped guide the committee regarding patient and provider concerns.

There are many complex health and financial requirements in over 90 pages of regulations. The first ten subchapters are health related, while the remaining five subchapters are insurance related and were drafted with the help of the Department of Insurance. Both departments share responsibility for regulating HMOs, and there's no better example of interagency collaboration.

Our proposed regulations were published in the *State Register* on May 20, to allow time for public comment. Adoption is expected in the fall.

I want to highlight some of the features of the regulations.

There are nine areas that are especially innovative and im-

*I created the HMO Advisory Committee, a group of physicians and other health care providers and representatives from HMOs, hospitals, and business and labor, and consumers.*

portant and I'll concentrate on them, beginning with the fact that we will be doing a comprehensive assessment of each HMO every three years to assure ongoing compliance with our requirements. This contrasts with our current practice, where we grant a certificate of authority and do very little monitoring after operations begin.

Also, we will require HMOs to go through an accreditation process every three years as part of a comprehensive assessment.

While the Departments of Health and Insurance know about HMOs, we believe we'll benefit from an external review by national organizations, such as the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Health Care Organizations.

For the first time, we will establish and collect outcome measures—both population based and patient based.

We'll do this through a Health Data Committee, which will develop and phase-in a set of outcome measures. Of

course, we immediately constructed an acronym: HeDaC.

HeDaC's mission is to advise the DOH on the development of a data-reporting system. Its job is to develop standardized, reliable, and comparable information.

One of the issues HeDaC faces is maintaining confidentiality. And HeDaC must devise a cost-effective data collection system, seeking to reduce duplication in data reporting. Most important, HeDaC must find a way to release the information that is meaningful to the public.

Ultimately, this data will be used by employers and consumers selecting HMOs and by DOH to monitor HMO performance and quality. We also will use the information to assess the HMOs' impact on public health.

The committee is made up of physicians and other health care providers, as well as HMO representatives and representatives from the Departments of Insurance and Human Services (Medicaid) and the State Health Benefits Commission.

Doctors are very much a part of this dynamic process and I want to thank MSNJ representative Dr. Eileen Moynihan for her participation and Dr. Art McLellan, as well as HMO representatives, Dr. Ron Brown and Dr. Deborah Hammond.

We will work closely with the HeDaC to develop a set of outcome measures that will include, for example, the number of women screened for breast and cervical cancers and the number of children immunized.

This is an extremely ambitious project. No other state is instituting this type of measuring system to judge HMOs' performance. In fact, only one other state—Nevada—requires reporting of specific outcome measures.

We will be in the forefront nationally with performance and outcome measures. In my view, this is the single most important contribution DOH can make to the monitoring and regulation of HMOs in our state.

We know that cost containment is the polestar of HMOs.



*These regulations are strong on patient rights. Under the proposed regulations, the HMO will provide each member a current copy of the benefits handbook.*

We will do what we can to make sure the star of quality shines just as bright.

Some measures, such as the number of adults immunized or the hospitalization rate for ambulatory sensitive conditions, already are available. Others, such as outcome measures for selected surgical procedures, will require more refinement.

Once the system is in place, we will have a set of measures that complement and reinforce each other. For breast cancer, for example, we can measure a plan's mammography screening rate, the percent of breast cancer detected in stage III or later, and the effectiveness of the screening program. We could then see which plans are more effective in managing care for women with breast cancer.

DOH will produce a standardized consumer satisfaction survey for members of each HMO.

Here are examples of the kinds of questions we'll be asking:

How much time for doctor and staff visits?

Did you have difficulty receiving care you and your doctor believe necessary?

Did you receive information from your plan about eligibility and covered services?

Eventually, that information will be included in our consumers' guide to HMOs. For the first time, employers and consumers will have solid, comparable information to help them make choices. We also will be asking providers for their evaluation of various aspects of HMO plans.

You've told us of the difficulties you've had with HMOs over utilization management decisions. Our committee heard you. Let me call your attention to our utilization management regulations.

Only an HMO physician can deny or limit a request for medical services.

UM staff must be available 24 hours a day, 365 days a year.

The patient or patient's doctor, acting on the patient's behalf, may initiate an informal appeal to the medical director or designee.

An appeal may be taken to a physician of the same or similar specialty.

Doctors cannot be penalized or terminated for discussing appeals of HMO decisions with patients.

We believe there has to be an external review process to ensure consumer confidence in HMOs. We wanted to do this, but at the same time, we wanted to create a system that reduces the administrative burden and creates incentives for the HMOs to resolve appeals internally.

We believe we have fashioned an appeals process that is fast, fair, and balanced.

Our proposed regulations create an appeals process that has two stages: the first stage is internal, where the patient or doctor acting on the patient's behalf, reviews the denial with the HMO's doctor. If the internal appeal isn't satisfactory, the patient or doctor then can request a formal appeal within the HMO, using a doctor of like specialty. If it still isn't resolved to the patient's satisfaction, an appeal may be taken to DOH.

## *Terminations or other penalties to the provider based on the filing of complaints or appeals is prohibited under the proposed HMO regulations.*

We will screen and forward it to an independent utilization review organization (IURO). This organization may not have an affiliation or relationship with any HMO.

The IURO will assign the appeal to a doctor of like specialty under contract with the IURO, and it then will issue a recommended decision.

The decision is nonbinding, but the HMO must advise DOH of its decision to accept or reject the IURO's recommendation. The appeal system will be financed through charges assessed against HMOs.

Doctors and patients are protected against retaliatory actions. Terminations or other penalties to the provider based on the filing of complaints or appeals are prohibited under the regulations.

HMOs must report aggregate information on financial incentives and disincentive arrangements with providers. We are modeling this after a comprehensive reporting format recently issued by NCQA.

All HMOs using financial incentives and disincentives must print a disclosure state-

ment with their enrollment materials and in the member handbooks. They also must advise members that they can call the HMOs for information about provider compensation.

Financial incentive arrangements such as withholds and/or bonuses are used with these various types of payment mechanisms.

Also, under these regulations (this portion of the regulations has been proposed) HMOs may offer point-of-service plans. Many believe this hybrid will become the dominant product in the industry because it offers incentives for remaining in the network, but the freedom to go outside the network.

These regulations are strong on patient rights. Under the proposed regulations, the HMO will provide each member a current copy of the benefits handbook, which includes a complete statement of patient rights, a description of all complaint and grievance procedures, and a summary of coverage.

Patients have rights to available and accessible services when medically necessary.

They have the right to choose a primary care provider within the plan network.

They have the right to be afforded a choice of specialists among participating network providers following a referral.

Members have the right to obtain a current—I emphasize current—directory of participating providers in the HMO network upon request.

They have the right to obtain assistance and referral to providers with experience in the treatment of patients with chronic disabilities.

They have the right to receive information on all treatment options regardless of whether they are covered benefits.

I come back to my original points. These regulations are the most progressive, consumer-oriented HMO regulations ever proposed. They address important consumer and provider issues, such as comprehensive three-year review, independent quality audits, independent appeals, outcome measures, member satisfaction surveys, utilization management controls, patient



## *The Department is evolving into the Department of Health and Senior Services, putting more than 30 programs under one roof.*

rights, point of service, and disclosure of financial incentives. And they were drafted through a participatory process with all parties at the table.

This is a time of great change, but rather than be paralyzed by change, we have to help direct it in ways that will improve health care in our state. Our proposed regulations will help us get there.

At DOH, we are directing change by assembling the pieces of a health information network with tools such as our cancer and birth defects registries, our electronic birth certificates system, and our immunization registry.

Let me tell you how we're already putting the information we gather to good use.

Data collected from our electronic birth certificate system, for example, showed us that our new law that gives mothers and their newborns a minimum of 48 hours in the hospital is working. We learned that length of stay for uncomplicated vaginal delivery rose from 1.3 days in the month before the law was passed to 1.8

days six months after the law was signed.

And we were able to see that this law reduced dramatically the number of newborns leaving the hospital with incomplete inborn errors of metabolism tests.

Our immunization registry will help you avoid missing opportunities to vaccinate patients. We are currently building the registry starting with the 187,000 children in the WIC program.

And our HMO outcome measures will help make sure these organizations are delivering on their promise of primary and preventive care.

DOH also is changing. We are evolving into the Department of Health and Senior Services, pulling more than 30 programs scattered in four different state departments and placing them under one roof.

For the first time, seniors will have cabinet-level status and one department will be responsible for all senior programs from advocacy to planning, licensure to inspection. While

we are consolidating on the state level, we will be launching a parallel effort on the county level to provide simplified access to senior services.

We envision a consumer-friendly system that will allow seniors easy access to all senior programs.

I promised you that DOH will stay close to the concerns of physicians.

We'll do that for a very pointed reason. You are the heart of the health care system. If you aren't happy with it, there's a good chance something is wrong.

Our HMO Advisory Committee had your concerns in mind when it made its recommendations for our proposed regulations.

We will have your concerns in mind when we develop our quality indicators.

We will continue to reach out to you so that we can chart our course together.

On a personal note, I want to say that the warm support of the medical community has been one of the most gratifying aspects of my

**NJM**

# COMMENTARY

## Hospitals prepare for their new role

Gary S. Carter, FACHE

Ask modern-day farmers, using leading-edge tractors, why they plant corn in rows 40 inches apart, and they may be hard-pressed for an answer. In the passing down of agricultural mores from fathers and grandfathers, few of today's farmers were told that the 40-inch row-mark was once the width necessary to accommodate a plow horse.

Farmers, of course, are not alone in their unquestioned obedience to outmoded notions. Hospitals also have hung onto age-old traditions like treating only the sick and the injured, and expecting patients to come to them for services. But all that is changing.

The most fundamental challenge facing hospitals today is the restructuring of the industry. Prior to 1992, New Jersey hospitals were tightly regulated entities, with no flexibility to reduce rates. But following deregulation four years ago, provider competition and managed care mania that had long been sweeping other parts of the nation gained formal access into New Jersey. While managed care and HMO penetration, without doubt, is making significant inroads here, it is not yet the prominent mode of delivery.

This past April, Dartmouth's John Wennberg, MD, MPH, the man who made "watchful waiting" and "shared decision making" common protocol with prostate disease, broke new boundaries with the release of the *Dartmouth Atlas of Health Care in the United States*. The *Atlas* is the first national report on geographic differences in health care delivery and on the dramatic differences in the distribution and utilization of health care resources.

There always has been the assumption that we have too many hospitals, too many beds, and too many health care professionals performing too many procedures; we simply have too much. The *Atlas*, even with the flaws inherent in the data, tends to support that suspicion.

But it won't always be that way. In New Jersey, hospitals are gradually transitioning from an over-bedded, fee-for-service environ-



ment to a wellness-oriented, capitated one. While hospitals face numerous challenges in making this transition, three challenges top the list: developing effective integrated delivery systems; improving physician relations; and assessing community health needs.

Building integrated delivery systems unCalifornia style. The most recent marriage of the Saint Barnabas Health Care System, joining eight acute care hospitals, seven nursing homes, five ambulatory care centers, and three psychiatric facilities, stands as testimony to the mammoth partnerships taking shape in New Jersey. While such unions will bring about the economies of scale that hospitals need to successfully maneuver the new landscape, they are not a panacea. Some New Jersey hospitals will close. One need only look west—to California—to understand why this is so true.

Despite the fact that metropolitan hospital occupancy rates in both northern and southern California are in the low forties, hospitals there have not closed in significant numbers. The reason being that much of California's excess hospital capacity has been propped up by multihospital systems. Jeff Goldsmith, PhD, president of Health Futures, Inc. in Bannockburn,

Illinois, points out that if many of California's flailing hospitals had "been left to the vagaries of the market, they would have closed.

Instead, however, they were rescued by stronger institutions under the premise that the whole would be greater—and more economically viable—than the sum of the parts."

The price of these altruistic decisions has been high. Many of California's multihospital systems now are in trouble—suffering declines in collected revenues and facing further capacity declines. Physicians affiliated with these systems are simultaneously struggling—and in some cases drowning—in an increasingly adverse economic climate.

New Jersey hospital leaders and physicians will learn from California and not make the same mistakes.

Improving physician relations. An equally important strategy for hospitals in the transition from fee-for-service is their working relationship with physicians. Physicians always have been important to hospitals, but today that importance takes on new dimension. With contracts shifting to capitation,

## COMMENTARY



Gary S. Carter

hospitals' focus must now move to keeping people healthy through the building of primary care networks.

## COMMENTARY

The New Jersey  
Hospital Assoc-  
iation (NJHA)  
has held several

educational seminars

on how physicians and hospitals can work together more effectively and more are planned. We've also cleaned cobwebs on our own oversight of physicians in our governance structure. Right now, NJHA is opening our corporate board to include more physicians, and we are looking for more physician input. This past January, prior to releasing—for the first time ever—primary hospital cesarean section rates to the public, NJHA convened an advisory panel of obstetricians to shed light on the surgical procedure. We plan similar data releases throughout 1996, and physicians will continue to be part of those discussions.

Unveiling community needs. A final challenge for hospitals comes in unveiling community health needs. In doing so, "health" must be defined broadly—moving beyond doctors and hospitals, skilled medical professionals, the right drugs, and the right machines—to include such issues as crime and housing and transportation. Hospitals and community groups must work together to see how—and if—identified needs are being met.

Many hospitals throughout the state are entrenched in community health assessments. In northwestern New

Jersey five hospitals—Overlook, Mountainside, Morristown, Newton, and Chilton Memorial hospitals—in conjunction with more than 75 community organizations worked with NJHA and a Pennsylvania-based consultant to develop a health assessment survey. Findings revealed that mental illness, allergies, and domestic violence were issues of concern, as was the fact that 38 percent of women had never been screened for breast cancer and 40 percent of men had never been tested for prostate cancer.

Within a year's time, these coalitions not only identified community health needs, but conducted focus groups to better understand why women weren't being screened for cancer and why domestic violence was a problem, to develop viable, long-term solutions.

At NJHA, it is our priority to help hospitals prepare for their new role in health care delivery. We want our state's hospitals to build effective integrated delivery systems—unCalifornia style. We want them to work in concert—not in conflict—with physicians. And we want them to uncover—not assume—the health needs of their communities. By achieving these three practical strategies, hospitals will be close to where they want and need to be. The type of care they deliver and their missions and responsibilities will be based on current—and carefully anticipated—need and not on unquestioned obedience to traditions that no longer make sense. *Mr. Carter is president, New Jersey Hospital Assoc-*

*iation, Princeton.*

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## TREATING LYME DISEASE: DIFFERENT APPROACHES

Dorothy M. Pietrucha, MD

*A physician's goal is to attempt to treat and eradicate the infectious agent and to give the patient some relief so the patient can function again.*

even after treatment with what is thought to be an adequate course of antibiotics.

From the beginning, when physicians began seeing and appreciating the fact that these patients were sick, it was obvious that a certain percentage of patients were not being cured with three, four, or six weeks of antibiotics—intravenous (IV) or oral.

The actual percentage of Lyme patients who are chronically ill is not known, but the morbidity for these patients is significant. Some patients have a persistent course and other patients have a relapsing, remitting course. The majority of patients cycle into a worsening of symptoms on a monthly basis.

Frequently, Lyme patients have symptoms referable to the central and peripheral nervous system including encephalopathy, polyneuropathy, and psychiatric symptoms. Some patients also have musculoskeletal complaints and some patients have involvement of other organ systems, e.g. the gastrointestinal tract, genitourinary tract, cardiac and cardiovascular systems.

The goal for any physician willing to help these patients is to attempt to treat and to eradicate the

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In April, I attended a conference sponsored by the Lyme Foundation and Mt. Auburn Hospital, in Cambridge, Massachusetts. The audience was filled with clinicians who treat patients with chronic Lyme disease. I felt vindicated when the information presented to the audience indicated the obvious persistence of this bacteria,

John W. Sensakovic, MD, PhD

*To treat Lyme disease effectively, it is of utmost importance that physicians understand the true nature of this disease.*

Lyme disease is but one of several *Borrelia* bacterial infections in man, transmitted by the bite of an infected insect vector. Included in the group are louse-borne relapsing fever, tick-borne relapsing fever, and Lyme borreliosis, transmitted by the bite of an infected *Ixodes* tick.

No infectious disease today is surrounded by the misconceptions and misunderstandings related to risk of infection, manifestations of the illness, and response to appropriate therapy, as is Lyme disease. An understanding of the true nature of Lyme disease clearly shows that misunderstandings and misconceptions surrounding Lyme disease have no basis of fact in the scientific literature.

Lyme disease is a multisystem bacterial infection caused by the tick-borne spirochete, *Borrelia burgdorferi*. Lyme disease is a zoonosis, in which humans can be inadvertently infected during this ongoing ecology of ticks, spirochetes, rodents, and other mammals. If infection occurs, and if disease results, it can present as early localized disease with the localized cutaneous erythema migrans (EM) rash, early disseminated disease with acute meningitis, carditis, and late disseminated disease with arthritis and neurological disease.

Although Lyme disease is the most commonly reported tick-borne disease in the United States, the

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## Pietrucha

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infectious agent and to give the patient symptomatic relief so that the patient can function again.

I hope that New Jersey physicians recognize patients who present with acute Lyme disease such as EM rash, swollen joints, and Bell's palsy, and treat these patients aggressively. The earlier the patient is treated, the greater the chance of a cure. Unfortunately, many patients move from this acute phase into a chronic phase and then it is more difficult to treat the patient.

There is no definite therapeutic regimen that is successful for the chronic Lyme patient. As a rule of thumb, the physician could consider treating the patient with antibiotics until the patient is well for four weeks and then treat four weeks beyond that point. This could result in months of therapy. The use of antibiotics for such a long period of time is controversial; however, we use this type of therapy in other illnesses such as acne and tuberculosis because we recognize the chronicity of the problem.

It is important for the physician to do an adequate differential diagnosis when the patient presents with symptoms and to make sure that there is not some other explanation for the problem. When one is convinced clinically that the patient is suffering from chronic Lyme disease, then treatment options include IV or oral antibiotics or a combination.

I use intravenous Claforan® as my first drug of choice for IV; my second drug of choice is Ampicillin® with the dosage being 100 mg/kg in three divided doses starting with a minimum of four to six weeks and extending the treatment where necessary. Other antibiotics used intravenously include Cedrixone®; Primaxin®; Amoxil®; Suprax®; Biaxin®; and Zithromax®.

Physicians in various specialties approach the problem according to their field of expertise. As a pediatric neurologist, I see a population with neurologic problems. To help patients with headaches, I used antidepressants. Physicians primarily seeing patients with musculoskeletal complaints use anti-inflammatories.

Literature on Lyme disease has been skewed in the direction of minimizing the chronicity of this problem. There are very few articles that are helpful to the

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## Sensakovic

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idea that transmission is easy is a misconception. An infected tick must feed for 36 to 48 hours before there is significant risk of infection for humans. Even in regions where high percentages of ticks are infected with *B. burgdorferi*, only 1 to 2 percent of bites actually will lead to Lyme disease in humans. Yet misunderstanding these facts frequently leads to ignoring simple yet useful protective measures for humans and their pets, and calls for unnecessary costly measures such as "tick analysis" and prophylactic antibiotics.

The clinical manifestations of Lyme disease are well described, and when present along with significant seropositivity, diagnostic specificity is very high. The misconception that Lyme disease frequently presents only with nonspecific symptoms such as fatigue and achiness leads to overdiagnosis. Scientific studies have shown in these instances most patients do not have Lyme disease. The misconception that persistent symptoms after treatment always means treatment failure can lead to gross overtreatment. Studies have shown that most instances of treatment failure are due to misdiagnosis. In other instances, the residual nonspecific symptoms have not been proven due to persistent active infection, and again should prompt a reconsideration of the diagnosis as well as an appreciation that these symptoms frequently resolve over time and respond to nonspecific treatments.

Seroreactivity for Lyme disease, when significantly positive in the appropriate clinical setting, is very useful in confirming the diagnosis. Difficulties can arise due to seronegativity early in infection, delayed antibody response due to very early antibiotic administration, laboratory variations, misinterpretations of results, and a significant incidence of "false positives" as high as 5 to 10 percent. These findings have been misinterpreted by some to mean everything from "serological testing is of no use and any symptoms even in seronegative patients are Lyme,"

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clinician for long-term management of the chronically ill patient with Lyme disease.

What do physicians need to do? I have given you an overview of an approach to take with regard to treatment. Long-term antibiotic therapy is fraught with problems for those who are willing to pursue it. Patients develop side effects; have allergic reactions; get opportunistic infections, have problems with central lines; and develop infections. All this must be monitored. Caring for patients with Lyme disease is very labor-intensive.

It is a crime that an illness, for which we know the etiology, is allowed to continue. Nothing is being done to curtail the number of infected patients. Each year, we see an increase in the number of patients because nothing is done to thin out deer herds and control the tick population in an aggressive manner.

The pharmaceutical industry must look at other antibiotics that might be effective against Lyme disease. We need more education for physicians. A yearly grand rounds in every hospital in New Jersey on Lyme disease should be considered. Lyme education for the general public is needed so the public can be aware of the potential seriousness of a tick bite. The insurance industry must accept the fact that some patients are chronically ill and that treatment may be long term and may be expensive.

What should a physician do if a patient comes in with a deer tick bite and the tick has been embedded for many hours? Should the patient be given a course of antibiotics when the tick is removed? This is controversial. There have been articles in *The New England Journal of Medicine* both pro and con for treatment.

Personally, I think it probably is safer and not very risky to give the patient a three-week course of Amoxil® or Doxycycline® after removal of the tick. Others would argue that it is not necessary to treat these asymptomatic tick bites but wait until the patient is sick. Treatment is very controversial and physicians who deal with Lyme patients have their own opinions about treating the tick bite and, for now, I think the decision should be between



## Sensakovic

*continued from page 52*

to the treatment of all seropositive patients even with no symptoms.

With such difficulties related to Lyme disease as a clinical diagnosis, it is not surprising that greater problems are seen related to treatment. When disease due to Lyme is present, with its diagnostic clinical syndrome and confirmatory serology, antibiotic therapy is very effective. The symptoms of early Lyme disease usually resolve spontaneously; treatment actually is used to shorten the duration of symptoms and to prevent later manifestations of infection. Oral therapy for 10 to 21 days is effective.

For disseminated Lyme disease, the duration of therapy usually is extended to three to four weeks, with parenteral therapy being used especially for late neurological and arthritic manifestations. Response here also is good, although some patients will experience nonspecific symptoms for a considerable period of time after therapy with antibiotics. These symptoms usually resolve spontaneously, with or without adjunctive measures such as physiotherapy and anti-inflammatory therapy.

The greatest difficulties arise in patients being treated for nonspecific symptoms, with or without seropositivity. These patients often are given greatly extended courses of antibiotics, sometimes repeatedly for months or years. Unproved and untested combinations often are used, even vancomycin, a seemingly most inappropriate antibiotic; and desperate measures including malariotherapy have been used. These approaches seem based on misinterpretations and misunderstanding.

Scientific literature shows that for other *Borrelia*-caused diseases, antibiotics are extremely effective. A single dose of antibiotics is a standard treatment for epidemic relapsing fever, a disease in which untreated patients have a mortality rate up to 40 percent. Similar effectiveness has been shown for *B. burgdorferi* infections in mice, where a five-day course of antibiotics was nearly 100 percent effective.

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## Sensakovic

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Persistence of *Borrelia* antigens in body fluids, detected by PCR, have been demonstrated in several studies after antibiotic treatment. This has been misinterpreted by proponents of long-term antibiotic therapy to indicate continued active infection. Studies in other infectious diseases, syphilis and tuberculosis, show that persistent PCR signals after treatment are common, can be prolonged, and do not correlate with lack of response to therapy.

Persistence or recurrence of nonspecific symptoms after treatment for assumed Lyme disease also is misinterpreted as treatment failure and an indication for prolonged antibiotic therapy. Yet, numerous studies have shown that the most common reason for such treatment "failures" is clearly a misdiagnosis in the first place.

The dangers of excessive antibiotic therapy are clear. Aside from the unnecessary cost, antibiotic-associated colitis and catheter-associated sepsis are all too common. Additionally, instances of antibiotic-associated gallbladder disease in young girls lacking adequate evidence for Lyme disease are well reported. Other problems such as unconventional treatments, as with malariotherapy, and overlooking serious other diagnoses add to the dilemma.

Why then would a physician ignore the scientific literature, and accept Lyme disease as a unique bacterial infection of man that can present with virtually any symptoms, often with no serological evidence of exposure, and be impervious to industrial doses of antibiotics?

Some physicians perhaps believe the disease to be unique, and with further physician education will re-evaluate that position. The great pressure that can be brought upon a physician for a diagnosis and treatment by a patient not feeling well, especially when the public and media enhance the misconceptions related to Lyme disease, often can lead a physician to treat even when the physician is not convinced of the

diagnosis. Perhaps with further public education and more responsible media coverage this too will change. Finally, there also is the occasional physician who undoubtedly sees a monetary advantage to such practices, and in these, hopefully rare instances, both the medical profession as well as the vulnerable patient suffer.

A competent physician can diagnose and treat Lyme disease appropriately by looking for objective evidence of true inflammation or organ dysfunction, serological or microbiological evidence of infection, not assuming seroreactivity is synonymous with active infection, and using antibiotic regimes that are recommended according to scientific clinical trials. If appropriate therapy does not lead to resolution, a physician should consider another diagnosis or an immunologic phenomenon rather than persistent infection as the cause.

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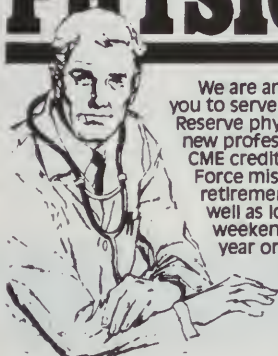
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JS96

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## *Here's what we are covering in August 1996*

- ⇒ How will New Jersey fund graduate medical education?

Writer Bill Berlin reveals the truth behind the funding problems for graduate medical education.

- ⇒ How do MSNJ policy statements on HIV/AIDS affect health care professionals?

MSNJ's presents its official 14-point policy statement on HIV/AIDS.

- ⇒ What did the MSNJ House of Delegates vote on during its Annual Meeting?

Read about the resolutions passed by the 1996 MSNJ House of Delegates.

- ⇒ How should New Jersey handle the debate concerning needle exchange?

Read this intriguing point counterpoint from two high-ranking health care professionals, Mr. McGarry and Dr. Day.

- ⇒ Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.

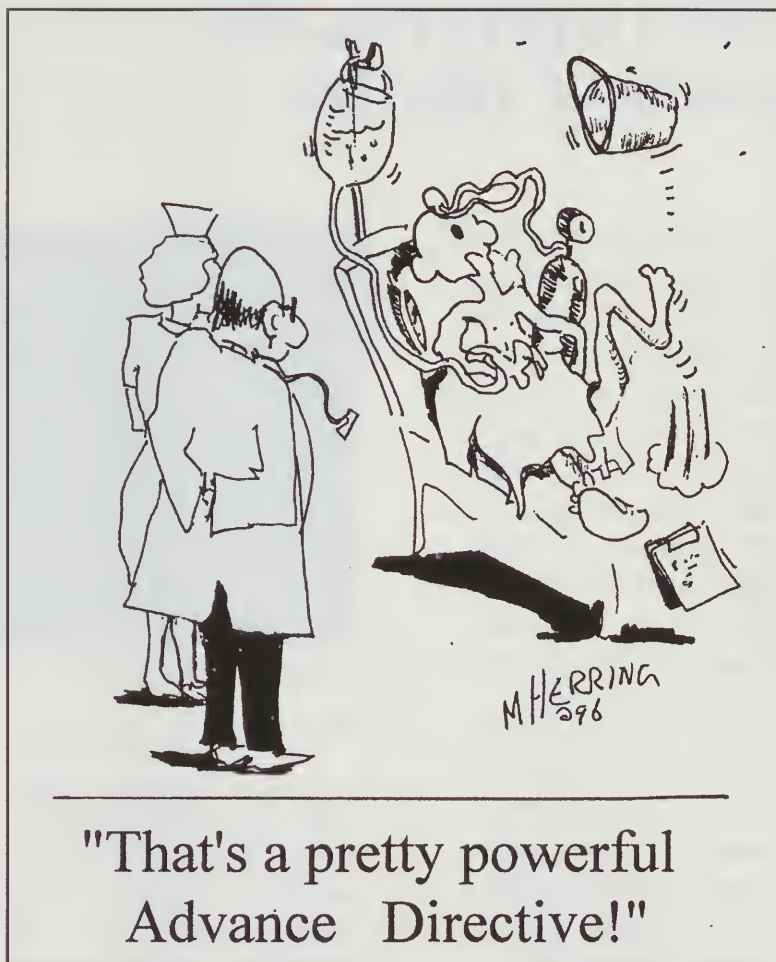
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## Physicians Advisory Council

Mary T. Herald, MD, of Westfield, has been appointed to the Practicing Physicians Advisory Council, which advises the Health and Human Services secretary on proposed changes in Medicare and Medicaid regulations that affect physician services. Dr. Herald is an endocrinologist and is an associate clinical professor of medicine at Columbia University College of Physicians and Surgeons, in New York. Dr. Herald also is a member of the Board of Trustees of Camp Neveda, in Stillwater, a camp for children with diabetes. She is affiliated with Overlook Hospital, in Summit and is a member of the AMA, MSNJ, and the Union County Medical Society.



Dr. Herald



**"That's a pretty powerful  
Advance Directive!"**

Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine.

## Raritan Bay awards Divino

Eumena M. Divino, MD, has been named the Distinguished Physician of the Year by Raritan Bay Medical Center, in Perth Amboy. Dr. Divino was praised for her unassuming manner and compassionate care and devotion to her patients during 23 years at Raritan Bay. Dr. Divino is a member of the Medical Executive Committee at Raritan Bay and served as chair of the department of obstetrics and gynecology. She is a member of MSNJ and of the Middlesex County Medical Society and also is board certified in obstetrics and gynecology.



Dr. Divino

## News from Mercer County

John A. Immordino, MD, received the Spirit of St. Francis Physician Award, given to a member of the St. Francis Medical Center staff who exemplifies compassion for all people. Steven W. Borrus, MD, was elected chief of internal medicine for Helene Fuld Medical Center. Angela Merlo, MD, was appointed assistant clinical professor of medicine at UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

## Arthritis Foundation honors Solomon

Sheldon D. Solomon, MD, of Cherry Hill was recognized for more than 20 years of service to the Arthritis Foundation, New Jersey Chapter and to the residents of New Jersey with arthritis. Dr. Solomon served on the chapter's medical and scientific, executive, and nominating committees; he also is co-director of the Arthritis Center at West Jersey Hospital-Marlton Division. Dr. Solomon is a member of MSNJ and of the Camden County Medical Society.



Dr. Solomon





## MSNJ ELECTS 1996-1997 BOARD OF TRUSTEES

MSNJ elected its 1996-1997 Board of Trustees. They are: (front row, left to right): Giovanni Lima, MD; Eileen M. Moynihan, MD; Anthony P. Caggiano, Jr, MD; Irving P. Ratner, MD, and Carl Restivo, Jr, MD. Second row, left to right: John W. Spurlock, MD; Stevan Adler, MD; Shah M. Chaudhry, MD; George J. Hill, MD; Robert S. Rigolosi, MD; S. Manzoor Abidi, MD; David A. Ingis, MD; Donald J. Cinotti, MD. Standing, left to right: Walter J. Kahn, MD; Louis L. Keeler, MD; Philip J. Jasper, MD; R. Gregory Sachs, MD; Churchill L. Blakey, MD; and Mark T. Olesnick, MD. Missing: Rajendra Prasad Gupta, MD; J. Jerome Cohen, MD; Richard M. Schwab, MD; and Christopher Ricci.

The meeting schedule for the Board of Trustees is as follows: July 21; September 18; October 20; November 17; December 15; January 19, 1997; February 16, 1997; March 16, 1997; and April 13, 1997. MSNJ members are welcome to attend the meetings.



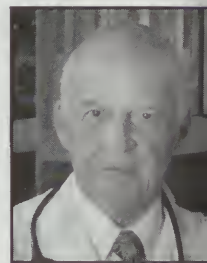
1996-1997 MSNJ Board of Trustees.

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### AHA awards

The American Heart Association (AHA) New Jersey Affiliate honored Victor Parsonnet, MD, with the Heart of Gold award in recognition of his lifelong, outstanding commitment to the advancement of cardiovascular research and science. Dr. Parsonnet has worked with AHA for the last 40 years. He is a member of MSNJ and its component, the Essex County Medical Society. The AHA also awarded Bristol-Myers Squibb Company re-

searchers David W. Cushman, PhD, Zola P. Horovitz, PhD, Miguel A. Ondetti, PhD, and Bernard Rubin, PhD, with the Discovery Award for their innovation of angiotensin-converting enzyme (ACE) inhibitors, used to treat patients with high blood pressure and congestive heart failure.

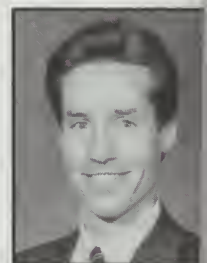


Dr. Parsonnet

### NJAO names new president

Ronald W. Kristan, MD, has been named president of the New Jersey Academy of Ophthalmology (NJAO). Dr. Kristan is an ophthalmologist at Monmouth Medical Center in Long Branch. Dr. Kristan is board certified by the American Board of Eye Surgery; a diplomate of the American Board of Ophthalmology and of the American Board of Eye Surgery;

and a fellow of the American Society of Ophthalmic Plastic and Reconstructive Surgery and the American College of Surgeons. Dr. Kristan also is a member of MSNJ and its component, the Monmouth County Medical Society.



Dr. Kristan

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**WILL A  
NEEDLE-EXCHANGE  
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# newsWATCH

**Consolidation is afoot in the Whitman administration, which now includes a new Department of Health and Senior Services (DHS2, formerly the Department of Health) under Commissioner Len Fishman, and a new Department of Insurance and Banking under Commissioner Elizabeth Randall.**

At DHS2, Deputy Commissioner for Senior Services **Susan Reinhard, PhD, RN**, will have her hands full melding components of four departments. Observers expect the biggest challenge to come from old-line Medicaid officials who are suspicious about the idea of transferring any component of the Medicaid program out of the Department of Human Services.

Dr. Reinhard and **Leah Z. Ziskin, MD, MS**, are deputy commissioners of DHS2, while **Anne Weiss** and **Elin A. Gursky, ScD**, hold the titles of senior assistant commissioner, also reporting directly to Commissioner Fishman. Ms. Weiss's area includes the health policy domains of managed care, acute care, and charity care, while Dr. Gursky administers traditional public health programs.

Specific organizational details still are being worked out. One additional change that has been announced, however, is the resignation of long-time DOH official **Terence O'Connor** as assistant commissioner for addiction services.

A glacial pace in the Department's granting of certificates of need (CN) has been observed by advocates of new construction and renovation of hospitals and health facilities. **George R. Laufenberg**, administrative manager of the New Jersey Carpenters Funds, has protested that only 6 of 40 pending CN applications have received final ap-

proval. The construction trades continue to experience high unemployment and underemployment.

**We are living in an era when charity care funding is in doubt as often as not. For example, it took the Legislature, Whitman administration, hospitals, and other health policy architects about six months to develop the latest package, which will expire at the end of 1997.**

The current package includes sharply reduced spending levels, less reliance on unemployment insurance as a funding mechanism, a vague and confusing commitment to managed care, and the virtual phase-out of the highly praised Access program of subsidized insurance premiums for the working poor. Even this mediocre measure may meet a higher standard than its eventual sequel, unless the parties come together to craft a better approach.

Change also is visiting the **Small Employer Health Program Board** and **Individual Health Coverage Program Board**, which run the standard insurance programs under reforms enacted in 1992.

Minority business representative **Lawrence Glover** has been named to succeed **Maureen Lopes** in the chair of the small employer board. Two-thirds of enrollees of small employer-based health plans now are in standard plans, but non-standard plans have been given a reprieve. The idea of standardization is to create a stable market to enhance access to affordable insurance.

On the individual front, Commissioner Randall intends to formulate recommendations to help stabilize premium prices for health coverage held by individuals and families not affiliated with employer-based plans. Nothing will succeed, however, like subsidies.

**Kevin O'Leary**, executive director for both programs, contends that the



boards have been a model of success by bringing the regulated parties to the table. This, he says, is a "healthy process for government."

**Smoking would be treated more as a disease and less as a hobby under diverse initiatives being taken in the wake of new federal guidelines on smoking cessation. The Agency for Health Care Policy Research (AHCPR) is urging all physicians to advise all patients who smoke to quit, and to give this advice during each encounter.**

Additional support for smoking cessation efforts could come from the **National Committee for Quality Assurance (NCQA)**, which accredits HMOs. NCQA is accepting comments on whether to include advice-to-quit as an indicator of HMO quality in the next version of **HEDIS** standards. Conformance with the standard would be determined through surveys of patients; those who smoke would be asked whether their physician had advised them against it.

In a related development, another influential, employer-based organization, the **Foundation for Accountability (FAact)**, has been asked to support including, within the recording of patients' vital signs, a notation of whether the patient smokes.

Amid some confusion, the **state Board of Medical Examiners (BME)** has released a proposal on managed care. BME wants to avoid micromanagement of physicians' economic incentives, such as proscribing payment schemes that may discourage necessary treatment.

But, BME intends to review on a case-by-case basis credible claims involving intentional undertreatment. BME also may set up a committee to review situations in which medical directors of HMOs, or other HMO officials, deny access to needed, covered care.

The **Medical Society of New Jersey (MSNJ)** has indicated overall

support for the BME approach, although some MSNJ leaders want BME to go further. Similarly, *The Star-Ledger* has editorialized in favor of stronger prohibitions. BME regulates physician behavior; DHS2 and the Department of Insurance and Banking regulate HMOs.

**"Don't undercapitalize, hire experienced financial personnel, don't discount the importance of profitability, doctors must play their governance part, doctors must hold majority ownership, streamline governance, and beware the effects of competing HMOs" is the advice given to physician-owned HMOs by the newsletter, *Physician Network*. The advice follows major changes at First Option Health Plan, including the removal of CEO John Adessa.**

In *The Milbank Quarterly*, a senior New Jersey researcher calls for more "trust-building" action by physicians. **David Mechanic, PhD**, director of Rutgers University's Institute for Health, Health Care Policy, and Aging Research, asserts, "Trust is typically associated with a high quality of communication and interaction." Under managed care, though, cautions Dr. Mechanic, perverse financial incentives, shorter patient visits, and commercialization combine to create an atmosphere where trust is eroded easily.

Among steps perceived by Dr. Mechanic as trust-building efforts are more physician and staff training to enhance communication skills, and education programs for patients and families.

Whales find objects by producing clicking noises that bounce back to them. This is termed "echolocation." Physicians, by contrast, are expected by patients to identify problems and solutions partly through conversation.

Neil E. Weisfeld



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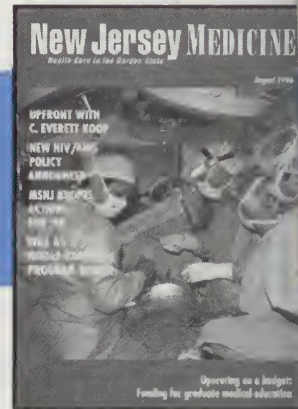
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Alan Graham, MD (center) chief of vascular surgery and the director of the Vascular Center of New Jersey, and his residents from UMDNJ-Robert Wood Johnson Medical School, operate at Robert Wood Johnson University Hospital.

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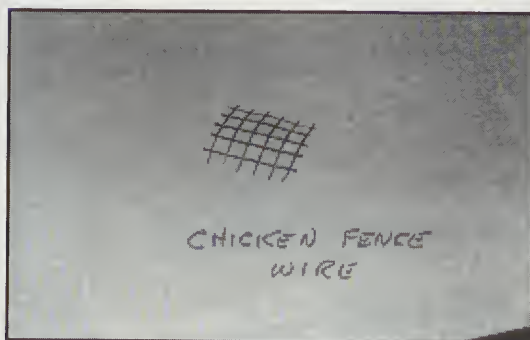
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## *Removal of radiopaque foreign bodies*

The ability to effectively remove foreign bodies, particularly in the extremities, when occasioned by good judgment, can make the family practitioner and general surgeon a hero to the average patient and to the insurance carrier.



**Figure.** Chicken fence wire.

The frequent opportunities to perform the procedure helped me to recall the very first "pearl of wisdom" I learned in my initial class in general surgery at Chicago Medical School approximately 35 years ago.

In my industrial medicine practice, it is not unusual for a worker to present with the suspicion of a metallic foreign body in the hand, arm, or leg. Of course, one must appreciate the value of good judgment

as to whether or not to attempt its removal.

The equipment required is an x-ray machine, a small surgical kit, plus the key item, a square piece of chicken wire with approximately 25 squares, 1/2" each box, which can easily be bent to conform to the shape of the area involved.

The chicken wire is placed over the area of probable entry of the foreign body under the middle square. X-rays are taken with the wire in place in two or three projections. It is not usual for the foreign body to be

located one or two squares away.

Once located, the foreign body can be removed under local anesthesia in only a few minutes much to the satisfaction of the patient and physician.

*Harold Fischer, MD*

## *Auld lang syne*

Your editorial, "Auld lang syne" outlines the changes of a new editorial policy for *New Jersey MEDICINE*. Whatever

the eventuality, I would appreciate attention to a higher profile for psychiatry. I feel there has been a neglect "of sorts" in the past. Each specialty, of course, has its own and specific journals. However, it is my impression that the relationship of medicine (in general) and psychiatry has a special priority at this time in the history of an unprecedented transition in the medical sciences. I hope this issue can be given a higher order of attention in the new format.

*Stanley E. Prentice, MD*

*Editor's note. We have always paid attention to the field of psychiatry and will continue to publish articles in this field. We encourage others in various specialties to write us.*

## *Comprehensive breast centers*

Having been part of two teams that have established two comprehensive breast centers, the most recent being The Jacqueline M. Wilentz Comprehensive Breast Cancer at Monmouth Medical Center, I want to enthusiastically endorse the value of multidisciplinary consensus building conferences as outlined in the article by August et al. in the

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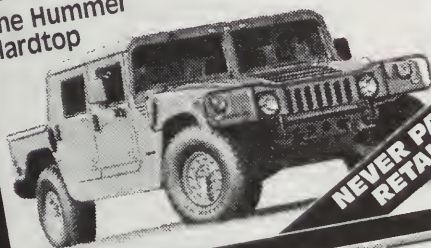
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\*\*As of June 20, 1996, the average waiting time for 125 patients was 77 ± 7 (SEM) days.



May issue of *New Jersey MEDICINE*. In existence since January 1994, the breast center at Monmouth Medical Center has experienced over 16,000 visits by women to date, a gratifying acknowledgement of the value to women of having all services required for optimum breast health care and breast cancer treatment included in one setting and delivered by one team. We have found, as has Dr. August that our patient satisfaction surveys garner very high grades, revealing women's appreciation for having such a program available. In addition, we also have noted that the opportunity for professional collaborative practice is meaningfully facilitated in such a setting.

Over the last decade, interest in establishing comprehensive breast centers has burgeoned, as noted in part by the increasing membership in The National Consortium of Breast Centers. This organization, created in large measure to facilitate country-wide collaboration for the development of breast center/centers of excellence, brings professionals together annually to share information that is pivotal to the establishment of breast centers. The organization

newsletter, *The Breast Center Bulletin*, also highlights and presents one breast center in each issue. Those who wish further information about this organization can contact Deborah Wiggins at 219/267-8058.

In an article published in the *Journal of Oncology Management*, the importance of physician champions is noted as one of the critical necessities for effectively establishing a comprehensive breast center. Dr. August and his colleagues are to be congratulated for not only championing the process, but for taking a lead role in developing and monitoring the breast center established at CINJ.

Barbara Rabinowitz, PhD,  
MSW, RN

Administrative Director, The  
Cancer Center, Monmouth  
Medical Center

### **MSNJ membership**

This is just a brief note to thank you for the thorough review of our managed care contracts over the past year. It has been helpful having Mr. Vincent Maressa, with his expertise and knowledge in this area, to review these difficult legal documents. My partners and I generally appreciate this work and the ability it

gives us to understand more clearly what these contracts entail. Contract review is another reason why we belong to the Medical Society of New Jersey (MSNJ), and it certainly is a reason why all physicians in this state should be MSNJ members when they see what MSNJ can do for its individual physicians with everyday problems especially in this era of managed care medicine.

Gary O. Siemons, MD

### **Chest radiographs in patients with community-acquired pneumonia**

The authors of the article, "Chest radiographs in patients with community-acquired pneumonia (93:37-41, June 1996)" would like to thank the following persons for their support: Bernard P. Shagan, MD, director and chair, Department of Medicine, for his invaluable advice and thoughtful review of the manuscript; the Department for Medical Records for its timely gathering of medical charts; and Linde Lynch for the efficient data entry and word processing. Also Drs. Wallach and Granet are fellows of the American College of Physicians.

Joseph Jaeger  
Monmouth Medical Center



## Honorary membership

Raritan Bay Medical Center President **Keith H. McLaughlin** was named an honorary member of the medical staff at Raritan Bay Medical Center, in Perth Amboy.

Mr. McLaughlin is president of the Raritan Bay Health Services Corporation; vice-chair of the Health Care Insurance Company/Princeton Insurance Company; and member of the Board of Trustees for the Center for Health Affairs.



## Assemblywoman honored

**New Jersey Assemblywoman Barbara W. Wright, RN** (R-District 14) was awarded the American Nurses Association 1996 Barbara Thoman Curtis

Award. The national award honors nurses who have made contributions to nursing and health policy through political and legislative activity. Assemblywoman Wright served as executive director of the New Jersey State Nurses Association.

## Governor's nursing award

**Shirley Horton, LPN, of Englewood, received the 1996 Governor's Nursing Merit Award, Licensed Practical Nurse—Acute Care category, at ceremonies in Princeton. The award, sponsored by the New Jersey State**



**Department of Health, recognizes excellence in nursing practice. Mrs. Horton is a pediatric nurse at Holy Name Hospital; she has been on the staff at Holy Name Hospital for 22 years. Governor Christie Todd Whitman and Commissioner Len Fishman were among the guests at the ceremony.**

## UMDNJ exhibit

"Foxglove, Featherfew and Candleberry: Herbs from the UMDNJ Libraries' History of Medicine Collection" is the title of an exhibit at the UMDNJ George F. Smith Library in Newark. The exhibit runs through February 1997. The collection features rare and antiquarian books from Special Collections, many of which were donated to UMDNJ by The Academy of Medicine of New Jersey. A lecture series with the theme "Herbs in Medical History" will be held in the fall in conjunction with the exhibit.



## Board appointment

**Fred Aueron, MD,** of Summit has been appointed to the National Board of Governors of the Society for Cardiac Angiography and Interventions. Dr. Aueron is director of Newark Beth Israel Medical Center's Invasive Cardiac Catheterization Laboratory; clinical instructor of medicine and cardiology at Newark Beth Israel Medical Center; and a partner in the Millburn-based cardiology practice, the Heart Group. Dr. Aueron is a member of the AMA, MSNJ, and the Essex County Medical Society.

## Home health officers

The 1996-1997 officers for the Center for Home Health Development elected into office are: Chair, Billiejean O'Brien, vice-president for Continuing Care, Clara Maass Health System; Vice-Chair, Jeffrey G. Blumengold, partner-in-charge, Healthcare, M.R. Weiser & Co.; Secretary, Jerry Cohen, president, Holy Redeemer Visiting Nurse Association; Treasurer, Kevin Rogers, senior vice-president, Finance and Administration, Patient Care, **NJM** Inc.





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### Whether to fight or to switch—or both

During World War II, servicemen diagnosed with venereal disease (VD) were classified as Line of Duty (LOD) No, Misconduct—and they were subject to court-martial. A mere handful of years later, during the Korean Police Action, service personnel who had applied for treatment and were found to have VD were listed as LOD Yes, as long as they had applied for treatment.

The military had not promulgated a new code of ethics. The change was made to preserve military manpower. The automatic misconduct applied during WW II caused many of the afflicted to attempt self-medication by the use of black-market penicillin, much of it of marginal efficacy, in order to evade punishment. The result, too often, was late-stage illness, requiring longer and less effective treatment, and the loss of many productive years of military effectiveness.

This was a classic illustration of morality versus pragmatism, the kind seen today in so many fields of interest. The Point Counterpoint in this issue presents the same dilemma and is the subject of this editorial. We still are at war.

Human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) continue to defy control, although much progress has been made recently, and their perception prevents them from being treated as public health problems, which they

deserve. Tuberculosis and cancer have been metaphors for illness, as Susan Sontag has explained, without interfering with proper control measures. HIV and AIDS are different.

Certain facts are not in dispute. New Jersey ranks fifth nationwide in the number of AIDS cases and is first in the proportion (55 percent) caused by intravenous (IV) drug use, a disquieting distinction.

The number of women infected via heterosexual relationships with drug abusers is an increasing problem, also greater in New Jersey. And the numbers of infected infants continue to rise. The latest New Jersey Judiciary Policy, dated May 27, 1996, puts it clearly and succinctly: "Contrary to national statistics, in New Jersey HIV infects injection drug users, including their sexual partners and children, more than any other identified group. AIDS is the leading cause of premature death in New Jersey and is

the leading cause of death for those aged 18 to 44. . . .HIV is not transmitted by casual contact. It usually is transmitted by blood-to-blood contact specially in the sharing of needles by injection drug users, during sexual intercourse, and from mother to child in the womb, during the birth process or through breast feeding."



Howard D. Slobodien, MD

*The perception of HIV and AIDS prevents them from being treated as public health problems. Yet, certain facts cannot be disputed. New Jersey ranks fifth nationwide in the number of AIDS cases.*



We have a problem. Some, including at least one member of the Governor's Advisory Council, feel allowing drug addiction to continue is unethical and thereby totally unacceptable, per se. There also is concern that the areas where exchanges take place produce "a dangerous environment." But the primary areas of contention are two: whether needle-exchange programs decrease the spread of HIV infection, and whether these programs promote drug use and abuse.

I feel awkward in disagreeing with moral(istic) points of view, particularly when promulgated from the pulpit. Nevertheless, I feel compelled to note that there are more lives at stake than just those of the addicted and that the ethically right or wrong position is indistinct and elusive. Furthermore, I am not sure that those who object to needle and syringe exchange also object to the use of methadone as an acceptable substitute (addiction) for those hooked on heroin, a somewhat affected stance.

The question about pollution of the environment is ongoing, but some reports, notably one from the Johns Hopkins School of Hygiene and Public Health in early 1995, showed no difference in Baltimore before and after the introduction of their needle-exchange program. (This and other references to studies in this article are available upon request.)

There has been a myriad of reports of needle-exchange programs since that time. The evidence from around the world is overwhelming; needle and syringe exchanges work—they decrease the spread of the virus and they do not increase the number of addicts. In fact, there is evidence showing that addicts with enough motivation to attend needle-exchange programs are the ones with a greater motivation to kick the habit.

In June 1995, the Lindesmith Center in New York City published "The Facts about Needle Exchange." It pointed out that almost all scientific bodies, including the United States Centers for Disease Control, supported the programs. It showed that these programs reduced the spread of HIV, and, if properly applied, could cut the risk in New York City by one-half. And it said governments should promote legislation to effect establishment of more programs.

The National Research Council and Institute of Medicine recently gave a ringing endorsement. Governor Whitman's own Advisory Council on AIDS also concurred, despite some internal disagreement; Governor Whitman, though, did not endorse such a program. And there is much more similar evidence, but the reader can obtain it from various sources on the Internet.

Suffice it to say, the disagreement is rupturing the fabric of our legal system. Many areas, in New Jersey and elsewhere, have laws proscribing exchange programs that are being defied openly. The Chai program, which distributes clean needles to intravenous drug users, operates in four New Jersey counties in open conflict with prosecutors. The *San Francisco Examiner* reported on May 23, 1996, that "a defiant Mayor Brown says the city will resist any attempt by state Attorney General Dan Lungren to end a three-year-old needle-exchange program designed to reduce the spread of AIDS among addicts."

When laws are flouted or ignored or disputed by a substantial number of responsible citizens, the laws probably need re-examination and change. We should hope that politicians would recognize the common good and do the right thing for innocent victims, despite the potential loss of votes. And of course, educational and treatment aspects should not only be continued, but should be expanded.

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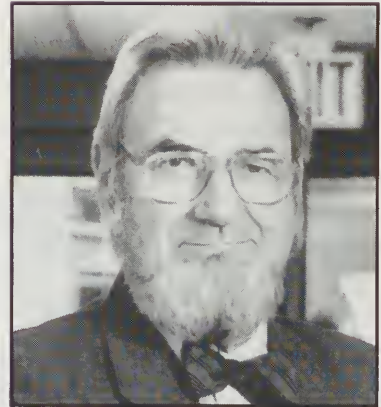
## INTERVIEW WITH DR. C. EVERETT KOOP

Dr. C. Everett Koop is the Elizabeth DeCamp McInerny Professor of Surgery at Dartmouth Medical School. Dr. Koop served as surgeon general from 1981 to 1989. He is a member of the American Surgical Association, the Society of University Surgeons, the American Pediatric Surgical Association, the National Academy of Science, the Institute of Medicine, the American Philosophical Society, and other professional societies in the United States and abroad. He is a fellow of the American College of Surgeons, the American Academy of Pediatrics, and the Society of Behavioral Medicine. He is chair of TIME LIFE MEDICAL. Dr. Koop is the author of over 230 articles and books on the practice of medicine and surgery, biomedical ethics, and health policy.

**Q.** One of the fundamental issues involved in graduate medical education (GME) today has to do with funding. How do you see this shaking out in the future?

**A.** That's not really clear, and I'm very concerned about it. There are three sources of funding other than tuition and gifts on which medical schools rely. The average medical school only takes in about 4 percent of its budget through tuition: Medicare provides a huge amount for graduate training and we don't know what's going to happen with that yet. The two other sources are the "surplus" that nonprofit teaching hospitals have, which they share with medical schools for GME, and then there's the "tax" that most deans put on income of the clinical faculty.

The sad thing is that all these sources are being attacked at the same time. Medicare is under attack by both houses of Congress, doctors aren't making as much money because managed care is not sending as many consultations to specialists, and beds are closing in many



C. Everett Koop, MD

teaching hospitals. So all three underpinnings of medical education are in jeopardy.

**Q.** So where does that leave GME?

**A.** I don't know the answer. If medical schools are going to be taken over by for-profit companies the way Columbia/HCA Healthcare Corporation has bought Tulane and the Medical College of South Carolina, that provides a certain stability, but it also raises ethical questions about who's teaching whom what.

I think some place, some time, there has to be a set-aside for medical education, because you can't continue to have decent doctors if you don't educate them. It's



*I think some place, some time, there has to be a set-aside for medical education, because you can't continue to have decent doctors if you don't educate them.*

complicated by the fact that now we have The Robert Wood Johnson Foundation and the Pew Commission saying that 30 medical schools ought to close voluntarily.

I can see that there can be conflicts and some possible mergers. I teach at Dartmouth Medical School, and I'm sure somebody's going to ask pretty soon why there are two rural medical centers an hour and one-half from each other in Burlington, Vermont, and Hanover, New Hampshire. Of course, they are across state lines, and those states don't have a history of working very well together. One medical center is a state university, the other medical center is private. If one of those were to close, or if they were to amalgamate, that would leave Maine, New Hampshire, and Vermont—a very sizable land mass—with only one medical school, and it is those schools that turn out physicians now for the northern New England region.

I think this is a huge dilemma, and I don't think it's being analyzed by those who have the most to say about it.

Somewhere along the line there ought to be an opportunity for the Institute of Medicine, AAMC, AMA, and the schools of public health to talk the subject out and come up with a proposal.

**Q.** Do you see this happening?

**A.** About 18 months ago, a dialogue began between the profession of medicine and the profession of public health in which I have been involved. We grew from about 18 people to 60 people, and then had a meeting attended by about 300 people in Chicago. The purpose was that these two specialties were becoming more and more divergent when they should have been coming closer together. Out of these meetings came a number of recommendations, some of which already are being implemented, to amalgamate the faculties from these two fields, perhaps virtually, in respect to teaching and other activities.

This is all well and good where the schools of medicine and public health exist on the same campus. But if you take New England, for example, there are three schools of public health in Boston, one in

New Haven, and none anywhere else. This has led to discussions in our neck of the woods about having a "virtual" school of public health, electronically, with a central coordinating office. I believe that this will become increasingly important in the way these two professions develop in helping each other.

In many cases, when we talk about GME, we are talking about what physicians have to do in most states to maintain their accreditation. That's another whole issue, and eventually it will be done in cyberspace and not by going to meetings supported by drug houses. This will be another revolutionary moment in medical education.

**Q.** What is your view regarding the impact of medical residencies on underserved populations in many urban and rural areas?

**A.** What has really taken care of the underserved is the National Health Service Corps. The Corps was gutted toward the end of the Reagan administration. There were some things put back during the Bush administration by the Democratic Congress, but it still is inadequate for

*There have been discussions in our neck of the woods about having a “virtual” school of public health, electronically, with a central coordinating office.*

underserved areas. And that’s another rat’s nest, because there are all sorts of problems with the National Health Service Corps. They’re wonderful young people, they do a very good job, and the enticement is that there are certain financial obligations that are removed if they decide to stay in one of those places of service.

I didn’t run the National Health Service Corps, but it was under my purview for eight years. So many times you’d find a young physician who might want to settle elsewhere. But as soon as they wanted to become a permanent fixture, the local medical establishment would say, “No, we really don’t need you.” You have all sorts of turf problems like that. It’s okay if you’re a freebie, but not if you are going to take some money out of the local economy.

**Q.** So many parts of the country are left with a severe shortage of physicians?

**A.** The distribution of physicians in the country is not equitable. We have about 40 percent of the people in this country on 90 percent of the land mass, which makes it



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difficult for places like Wyoming, Montana, Washington, Maine, New Hampshire, and Vermont, where there are really long stretches between physicians and medical clinics.

A lot of the little hospitals that were built in great numbers during the Hill-Burton years have closed. In my personal experience, the sad

part about it is that consideration before closing a hospital in, say, Appalachia has been inadequate—and hospitals there are 30 miles apart. They may decide to get rid of the one in the middle, so

that now people have 60 miles to travel. The government even went to the effort of doing surveys of people in these areas, asking how many of them own cars. Well, they came back and said, “This is going to work, because 98 percent of the people have cars.” What they didn’t ask is if they had tires on the cars or holes in the gas tank, or if they had

money to buy gas. And the fact is that many of them could not travel 60 miles.

**Q.** Apart from the National Health Service Corps, how else can we alleviate this problem?

**A.** I think one of the things that can help is for us to face the fact that doctors who go to these places face both geographic and intellectual



*The distribution of physicians in the country is not equitable. We have 40 percent of the people in this country on 90 percent of the land mass, making long stretches between physicians and clinics.*

isolation. Part of that can be helped again by high-tech, cyberspace communication. I have some experience with this at Dartmouth, and I know that if you get these people networked together, it can help. I've sat down with 140 rural doctors and asked them, "What is the thing you miss most in the world?" They say that it's being able to walk down the hall and go to someone's office and say, "What do you think of this chest x-ray?"

It's even possible now with a telephone line and a \$1,500 installation to be able to do that. We've got an experiment going in the Adirondacks now where we have 11 clinics hooked up with a \$1,500 Picasso telephone, and the savings each time it is used is about \$500. It's good for the system, it's good for the doctors, and the patients are more satisfied.

**Q.** In New Jersey, the problem of access plays out somewhat differently. Here, our urban hospitals are heavily dependent on foreign medical school graduates to staff residencies that serve an indigent population.

**A.** Well, it's another sort of "Catch-22" situation. We are

facing the fact that we don't have enough doctors in rural areas, yet at the same time we have people screaming to close medical schools because we're turning out too many doctors. The whole thing comes down to distribution, and one of the things that the United States refuses to recognize is that you have to come to grips with the foreign influx of doctors. You can't keep cutting American students out of the opportunity to go to medical school and bring in foreign physicians who are not nearly as well trained. At the Koop Institute I'm trying to change the communication abilities between physicians and patients, but if you add to the mix the fact that a doctor doesn't speak English very well, you've got another serious problem.

**Q.** Given the record number of applicants to U.S. medical schools, if you limited the number of international medical graduates, wouldn't our graduates be forced to go to underserved rural or urban areas?

**A.** It doesn't seem to work that way. Your logic tells you, and economics tells you, that if you can't get a job in New

York, you go to Springfield. But people don't like to do that. I have to add this, however. The profile of the average medical student today compared to 10 or 20 years ago is better suited to rural medicine. I think that the young breed of the last 3 years is very different, especially compared to those of 20 years ago. I despaired of some medical students back then because I think many of the brightest of them were there because it was the quickest way to make money. They were examination passers who could have done a hundred things, but they chose medicine because of the economic advantages.

But now, these young people don't talk about money at all. Many of them have had two years or more between college and medical school doing pro bono work and they're interested in folks, they're interested in not just the economic outcome of medicine, and not just the outcome of medical disease, but in the sociocultural things that happen to families and communities. I think you are more likely to see this type of medical graduate relocating

*Medical students should have seminars with physicians in all four years to keep them abreast of current medical affairs. It is difficult to interpret media reports and know what they mean.*

and going into less served regions.

Also, with the independence of doctors being taken away through the growth of managed care, these areas might be among the few places left where you have some semblance of autonomy.

**Q.** My impression is that on the state and federal level the issue of graduate medical education is a prisoner of political forces. On the state level in many places the anti-tax atmosphere prevents any kind of creative action. On the federal level, the solution seems to be to cut, which again is more political expediency than real policy.

**A.** You're dead right about that. The country's not looking to Washington, DC, any more for solutions because there are no solutions there. The way Congress and this administration have undercut the health part of government is really pitiful. Usually Congress and the executive branch balance each other, but not in this case. Whether it's the "Contract with America" or "Reinventing Government," they have either weakened or eliminated all of the offices that supply the public health of this country.

**Q.** What do you see as some of the consequences of this weakening?

**A.** I really worry if we had another AIDS-type epidemic that could kill people quickly, we'd have a panic in this country because we wouldn't be able to handle it. It's a curious thing about epidemics—the so-called "tipping factor" or critical mass is there all the time, but all of a sudden it erupts like a mushroom overnight. When AIDS first came on the scene and we then found what the antibody to the virus was, we went back and looked at serum we had in San Francisco from homosexual studies on hepatitis. The antibodies were there 11 years before we knew about AIDS. In Louisville, Kentucky, at the drug addiction hospital, we looked at other batches of serum, and 14 years before we knew about AIDS, antibodies were in that serum. So AIDS was with us a long, long time before it suddenly erupted. Right now, we're at equilibrium. We get 40,000 new cases a year, and 40,000 people die. If we could just cut down the new cases a year to 35,000, the epidemic would start to go away.

**Q.** So basically you're saying that the federal government is sort of shutting down when it comes to health planning?

**A.** No question, and it's a sad and worrisome thing for those young people who are now in medical school. But it's interesting that they don't share that worry.

**Q.** It is interesting, because many applicants to medical school seem to have little idea of what's going on in the professional world of medicine.

**A.** I think we take better care of carpenter apprentices than we do of "apprentice" physicians as far as the realities of the profession are concerned. Medical students should have seminars with practicing physicians in all four years to keep them abreast of current medical affairs. It is very difficult to interpret the reports from the media and know what it means for the practice of medicine.

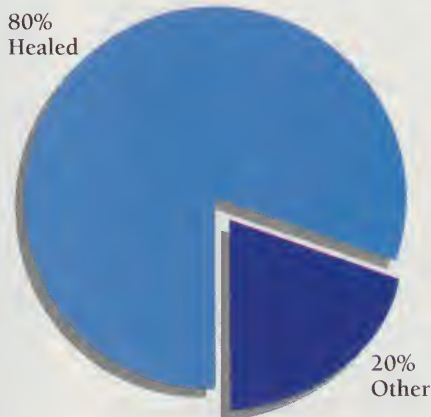
Even premedical students should be kept apprised of current affairs. I do this for undergraduates at Dartmouth. Last year, there was an elective for undergraduates at the college on the history of health care. An enrollment of 30 to 40 was expected; 90 signed up.



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## Graduate medical education: Where do we go from here?

Bill Berlin, PhD

The tremors that are shaking the world of medicine are reshaping the landscape of graduate medical education (GME), and along with it, the future of the medical profession in the United States. GME—essentially medical residencies and, to a lesser extent, research fellowships—is the crossroads where career aspirations become professional choices, and where decisions are made, both on a macro and micro level, that will shape medicine for years to come.

For these reasons, GME hardly exists in a vacuum. Funding for medical residencies is strongly dependent on federal and state budgetary policies, the growing influence of managed care, and expectations about health and population trends.

One of the major factors that influences the debate over GME is the widely held assumption that the nation is facing an oversupply of physicians. According to the Institute of Medicine, the

number of physicians in the United States has grown from 150 per 100,000 people in 1970 to 245 per 100,000 in 1992, an increase of 1.5 times the rate of the general population. Given the record number of applicants to U.S. medical schools in recent years, this rate of growth is

Dr. Marc L. Rivo and his colleagues argued that an appropriate ratio in a health care system dominated by managed care is between 145 and 185 physicians in patient care per 100,000 population, a ratio already exceeded in this country.



Dr. Graham (front right), a member of the University Medical Group, and his residents review x-rays after surgery. © Conrad Gloos

expected to continue for at least another decade.

To a number of analysts this trend especially is troubling in light of the emergence of managed care and the move toward consolidation throughout health care. In a 1996 "report card" on the physician workforce in the United States published in *The New England Journal of Medicine*,

As a result, a spate of studies has recommended a sharp downsizing of the medical profession, and of GME in particular. The Pew Health Professions Commission in its 1995 report, "Critical Challenges: Revitalizing the Health Professions for the Twenty-First Century," called for reducing the size of entering medical school classes by as much as



25 percent by 2005, closing medical schools in areas of the country where there is an oversupply of physicians, and decreasing the number of graduate medical training positions to the number of U.S. medical school graduates plus 10 percent. In addition, the Commission recommended changing GME so that by the year 2000 at least one-half of all training programs are in the primary care areas of family medicine, general internal medicine, and general pediatrics.

Several states have moved to cut GME funding, and both the Clinton administration and the Republican-controlled Congress have proposed slashes in Medicare funding that subsidizes medical residencies. In a recent report, the Institute of Medicine, which often advises federal policymakers, called on the federal government to reduce the number of medical residency positions it funds. Citing the likelihood of an "appreciable surplus" in coming years, the Institute of Medicine report recommended other measures to scale down the profession, including a freeze on class sizes and on opening new medical schools. "Producing more physicians than the nation requires is a waste of both human resources and the federal resources spent on residency training," said Neil Vanselow, professor of medicine at Tulane University, who co-chaired the committee that produced the Institute of Medicine's report.

While there is considerable agreement about the prospect of physician oversupply, some observers are wary about taking strong steps to curb medical education on all levels. The American Association of Medical Colleges (AAMC) and a number of medical professional associations have taken issue with some of the Pew Commission's assumptions, notably in regard to health and demographic trends. Demographic projections are not always reliable, and unforeseen health phenomena, such as the emergence of AIDS or the possible resurgence of antibiotic-resistant bacterial infections, could create new demands on medical services. "A change of even one assumption in physician trend studies will skew things greatly," warns David Swee, MD, chair of the Department of Family Medicine at UMDNJ-Robert Wood Johnson Medical School, and vice-chair of the MSNJ Council on Medical Services.

Moreover, AAMC and other organizations prefer limiting the growing number of international medical graduates (IMGs) in residency training programs as a first and fairer step in reforming GME. Between 1988 and 1994, the number of foreign-born graduates in U.S. residency programs rose by more than 160 percent, from 2,201 to 5,891, while the number of residents from U.S. medical schools remained steady at about 17,000 a year. "If you cut residencies without cutting the number of IMGs," says Dr. Swee, "you'll have a lot of medical school graduates looking for work."

For many IMGs, the U.S. has been the promised land and urban hospitals have been ports of entry. This is especially true in New Jersey where in 1994, 43.9 percent of all residents were foreign-born graduates of international medical schools, the highest percentage of the nation. Urban hospitals often are heavily dependent on IMGs to staff residency positions considered less desirable by U.S. medical school graduates, and these residents provide vital patient services to indigent clientele. One nationwide survey found, for example, that of 106 teaching hospitals with IMGs staffing at least 50 percent of first-year residences, 77 of these hospitals provided a disproportionate amount of care to the poor.

In New Jersey, the GME issue is complicated by funding cutbacks. For years, Medicare and Medicaid funding have provided direct and indirect reimbursement for medical residencies, which many urban hospitals have relied upon for patient care. The more residencies a hospital has staffed, the more money it has received, and the more services it has been able to provide for indigent clients. Replacing these medical residents with physicians, physician assistants, or nurse practitioners would raise costs and probably lead to a reduction in services.

The New Jersey Health Care Reform Act of 1992 eliminated charity care funding, and along with it an important source of GME funding, leaving urban hospitals even more dependent on Medicare and Medicaid resident training reimbursements to subsidize their patient services. Now, dramatic cuts in Medicaid and proposed reductions in Medicare funding have created a "very serious situation" for

GME, according to Tom Terrill, president of University Health Systems of New Jersey.

The growth of managed care also has altered the logic behind the old funding mechanisms. Increasingly, managed care is attracting Medicare patients who formerly were treated in hospitals. But most HMOs are not passing on part of their Medicare premium to educational programs or teaching hospitals. Likewise on the state level, increasing amounts of GME dollars are being contracted to HMOs through the state's managed care initiative. So, in essence, critics charge, managed care organizations, as well as corporations and insurance companies are reaping the benefits of GME without paying their fair share to support it.

While Terrill agrees that there has to be a gradual decline in the level of support for GME, he believes that the method of funding resident training needs to be reformed. He is not alone. Many health care policy experts recommend moving away from the current dependence on Medicare reimbursements to an all-payer system in which all beneficiaries of GME contribute to its support.

To this end, the Pew Commission recommended a public-private pool tied to all insurance premiums to help finance GME. In New York State, Governor George Pataki has proposed two new taxes on insurers, including large employers that provide health insurance for their workers. One tax would provide money to hospitals that treat the poor, and the other tax would support training programs at teaching hospitals.

In New Jersey, the reigning anti-tax atmosphere probably precludes this type of solution. Three years ago, UMDNJ and the Advisory Graduate Medical Education Council proposed a 25 percent reduction in the number of residency positions by 1997, and an assessment on gross hospital revenues to support GME and health professions education. These rec-



*Dr. Graham and his residents assess their patient in the surgical intensive care unit at the Robert Wood Johnson University Hospital. ©Conrad Gloos*

ommendations have gone unheeded, with the state relying on deregulation and reduced appropriations to change the playing field. Governor Christine Todd Whitman's fiscal year 1997 budget would have eliminated GME funding for all hospitals with fewer than 45 residents, a proposal that was scrapped in the final version of the document. Still, some change in residency training seems imminent. "We're on the front side of change in GME," says Paul F. Larson, MD, vice-president for academic affairs at UMDNJ. "I personally think that a decrease in residencies in the state is inevitable."

The fate of GME depends heavily on federal and state policies, which for now lack coherence and direction. In Congress, a coalition of urban and rural representatives have successfully blocked initiatives to change Medicare reimbursement policies and discourage hospitals from using IMGs. Proposals to expand the National Health Service Corps, a program that offers scholarships and loan repayments for work in underserved areas, have failed to generate sufficient political support. At the state level, it has been easier to cut GME reimbursements than to create innovative funding mechanisms. The result is that GME languishes in the waiting room, still needing appropriate professional attention.

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# COMPLETE ABSENCE OF THE PERICARDIUM WITH BRONCHOGENIC CYST

Richard B. Ruchman, MD  
Bokran Won, MD

**The authors are affiliated with the Department of Radiology, Monmouth Medical Center, Long Branch.**

This is a case report of complete left-sided pericardial defect in association with a mediastinal bronchogenic cyst, which was demonstrated on computed tomography (CT). This is thought to be the first case report of complete absence of the left pericardium with a mediastinal bronchogenic cyst documented on CT.

**Case report.** A ten-year-old boy with a history of mild asthma presented to the hospital emergency room after swallowing a quarter. Chest radiograph (Figure 1) revealed a large round mass in the left anterior mediastinum. The subsequent CT scan of the chest revealed a 6 cm, well-circumscribed soft tissue mass in the left anterior mediastinum (Figure 2). The mass was homogeneous of soft tissue density and well-circumscribed, and appeared to abut the mediastinal structures including the main pulmonary artery. A careful review of the CT scan failed to depict the pericardium on the left (Figure 3).

The patient underwent a left thoracotomy and was found to have a completely absent pericardium on the left and a cystic structure that was attached to the mediastinum. The pathological examination revealed this mass to be a bronchogenic cyst. The postoperative chest radiograph showed deviation of the cardiac silhouette to the left with minimal deviation of the trachea to the right (Figure 4). In addition, there was lucency between the left hemidiaphragm and the inferior portion of the heart. The postoperative clinical course was unremarkable.

**Discussion.** A pericardial defect is a rare congenital anomaly with an unclear etiology.<sup>1</sup>

Embryologic evidence suggests that the formation of a pericardial defect is closely related to development of the pleuropericardial fold and atrophy of the duct of Cuvier.<sup>1,2</sup> Normal development of the duct of Cuvier is responsible for the proper development of pleuropericardial folds.<sup>1</sup> The right duct of Cuvier normally persists as the superior vena cava.<sup>2</sup> The left duct of Cuvier normally atrophies. However, premature atrophy of the left duct of Cuvier results in a left-sided pericardial defect due to loss of the blood supply to the pleuropericardial fold.<sup>2</sup> In addition, early atrophy of the duct of Cuvier might be responsible for abnormal budding of the lung



**Figure 1.** Chest radiograph shows the left mediastinal mass with the heart in normal position.



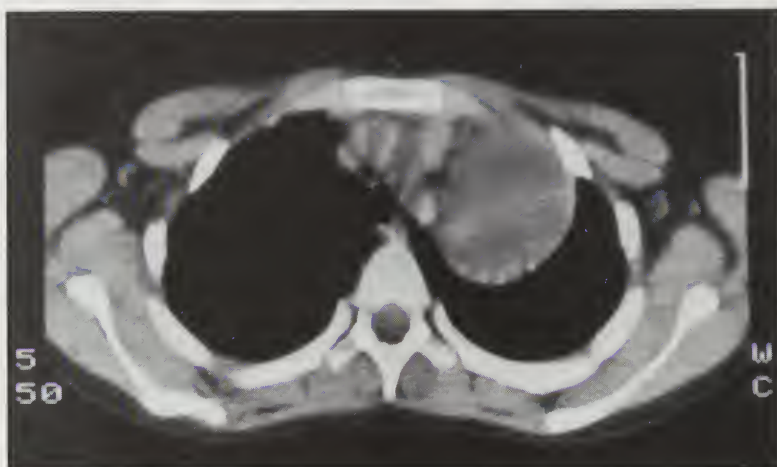
# *A pericardial defect is a rare congenital anomaly. Embryologic evidence suggests that the formation is related to development of pleuropericardial fold and atrophy of the duct of Cuvier.*

resulting in a bronchogenic cyst, abnormal fissures, sequestered lung, and aberrant lobes.<sup>1</sup>

Pericardial defects may be described as partial or complete and unilateral or bilateral.<sup>1</sup> Approximately one-third of the reported cases of pericardial defect have associated congenital cardiac or pulmonary anomalies.<sup>3,4</sup> The anomalies include bronchogenic cyst, patent ductus arteriosus, pulmonary sequestration, atrial septal defects, tricuspid insufficiency, mitral stenosis, and tetralogy of Fallot.<sup>3</sup>

The radiographic features of complete left-sided pericardial defects include: interposition of lung between the left hemidiaphragm and the heart or between the pulmonary artery and the aorta; deviation of the heart to the left without displacement of the trachea; and unusually mobile heart.<sup>5</sup>

In 1980, Balm described the CT appearance of complete absence of the left pericardium. Rotation of the main pulmonary artery with interposition of air between aorta and prominent pulmonary artery and abrupt interruption of the pericardium allowing the heart to protrude into the left lung were depicted.<sup>2</sup> The characteristic radiographic and CT appearances



**Figure 2.** Unenhanced CT reveals a mass in the left anterior mediastinum.

of mediastinal bronchogenic cysts have been well documented.<sup>6,7</sup> On chest radiograph, bronchogenic cysts usually are solitary, either round or oval, well-circumscribed mediastinal masses. On CT scan, cysts appear as homogeneous and high attenuation masses with CT numbers ranging from -3 to 120 HU and usually contain mucoid material.<sup>6,8</sup>

CT manifestations of complete absence of the left pericardium with associated mediastinal bronchogenic cyst have not been reported. In this patient, CT examination illustrated absence of the left pericardium and a mediastinal bronchogenic cyst. There was no evidence of lung present between any mediastinal structures. The characteristic features that were reported by Balm were not evident on the

CT study. This can be explained by the coexistence of the left-sided mediastinal bronchogenic cyst with the pericardial defect, which modified the expected anatomical changes. Initial chest radiograph did not demonstrate the anticipated findings and the typical radiological appearance of complete absence of the pericardium was seen only after removal of the bronchogenic cyst.

In this patient, followup CT scan after thoracotomy was not performed. However, the authors believe that CT would have illustrated the characteristic findings of complete absence of the pericardium, which were previously described. The authors postulate that there might have been abnormal development of the left duct of Cuvier resulting in a complete absence of pericardi-

*The only finding on computed tomography might be the easily overlooked absence of the pericardium while more conspicuous associated findings might be absent.*

um and a bronchogenic cyst on the same side.

This case report details the CT characteristics of a congenital pericardial defect with an associated mediastinal bronchogenic cyst, including the embryologic association between the two congenital anomalies, a pericardial defect and a bronchogenic cyst. Unlike the CT features of an isolated complete pericardial defect, those of the complete pericardial defect with another congenital anomaly such as a mediastinal bronchogenic cyst are difficult to detect. The only finding on CT might be the easily overlooked absence of the pericardium while more conspicuous associated findings might be absent.

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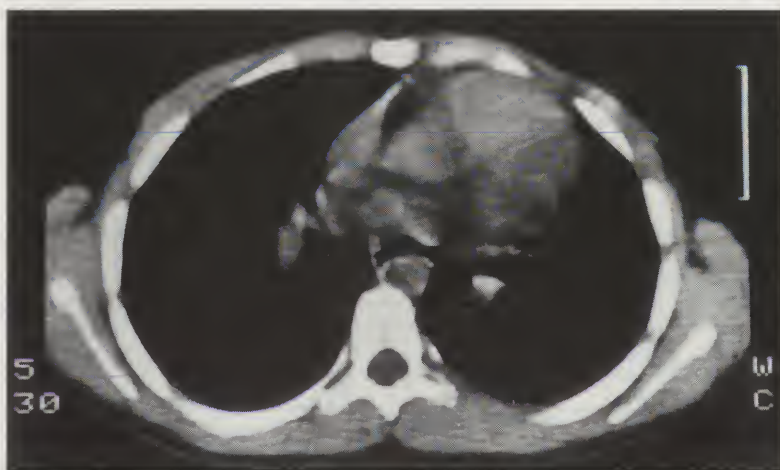
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**Figure 3.** Unenhanced CT shows absence of the pericardium.

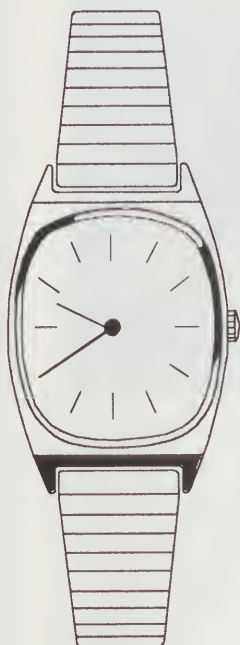


**Figure 4.** Postoperative chest radiograph demonstrates levoposition of the heart and interposition of the lung between the heart and the hemidiaphragm.



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you felt a sharp  
pain in your right  
arm and side ...



It's 3:35  
In the afternoon ...  
the doctors confirmed  
that it **WAS** a  
heart attack ...



It's 8:05  
In the evening and  
you begin to wonder  
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## OFFICIAL POLICY STATEMENT ON HIV/AIDS

HIV/AIDS affects the lives of millions of people, and has claimed the lives of many. With a focused effort of medicine, public health, and government, this disease can be brought under control. With this in mind, the MSNJ Council on Public Health drafted a 14-point policy dealing with AIDS/HIV. Submitted to the Board of Trustees, this document was adopted as the official policy statement on HIV/AIDS. MSNJ presents this statement for review and evaluation.

**Philosophy.** This pandemic infection affecting the lives of millions of people must be brought under control. This requires the concerted efforts of medicine, public health, and government. HIV/AIDS is a disease and should be dealt with as such.

**Universal precautions.** MSNJ endorses standards for the prevention of transmission

of bloodborne pathogens, commonly called universal precautions. Universal precautions include hand washing, disinfection, handling and disposal of needles, and barrier techniques, including gloves and masks.

### **Mandatory testing.**

While early detection of HIV infection could facilitate timely treatment and could help to reduce future transmission, mandatory testing currently is considered inappropriate or impractical, except for very specific circumstances, such as screening of the blood supply.

### **Voluntary testing.**

MSNJ strongly advocates routine universal voluntary HIV testing of all individuals in New Jersey. Extensive pretest counseling is not necessary, but every patient should be given information about the advantages and disadvantages of testing. However, this testing should not be done on patients who specifically refuse the testing. Testing can occur in hospitals or any health care facility. In addition, MSNJ recommends that HIV testing be covered under health

insurance policies in the state of New Jersey, including Medicaid.

### **Disposition of HIV positive cases.**

Patients with positive tests require counseling. This may be done by the physician, or the patient may be referred to a specialist or appropriate clinic. Every physician or facility ordering HIV testing must provide post-test counseling for those with positive tests. Reimbursement for counseling should be provided by the insurance carrier. The reporting of HIV-positive individuals to the New Jersey State Department of Health, with identifiers, is supported as a positive public health measure. Notification of contacts may be done by physicians or may be referred to the authorized public health agency. Physicians shall not be liable with regard to the loss of patient privacy. Legislation that would shield professionals from this liability shall be supported. Access to specialists should be assured and funded by third-party payers.



**Request for information.** Information from hospital or physician office charts including HIV status will be provided after suitable patient release is obtained in accordance with current medical practice. There is to be no selective release of medical information. Physicians and hospitals are to be protected, under law, from liability for appropriate release of medical records.

**Obstetrics.** HIV counseling and testing must be offered to all pregnant women. Refusal to accept counseling and testing or treatment shall be documented in the patient's chart.

**Criminal behavior and prison inmates.** HIV infection per se should not alter the manner in which a perpetrator is judged by the law. HIV status should not be used to determine prison inmate entitlements to medical services. Voluntary testing should be offered at the time of incarceration. Retesting should be done as appropriate.

**Protection from discrimination.** No employer will be permitted to refuse to hire an employee or terminate an employee solely because of a positive HIV status. No health insurance carrier may deny medical insurance solely and

specifically because of HIV status as a separate medical condition. Physicians who are known to be HIV positive and thereby sustain diminished opportunity to practice medicine should be considered disabled under the terms of their insurance programs. Health care workers shall not refuse to treat a patient solely because that individual is thought or known to be HIV infected. MSNJ should endorse and



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facilitate public education aimed at decreasing HIV discrimination in the workplace.

**Legislation.** MSNJ shall maintain, via its Councils on Public Health and Legislation, an active interest and involvement in AIDS legislation and education.

**Comprehensive school health education.** MSNJ supports comprehensive school health education curricula to include HIV infection and AIDS. This would include educational programs emphasizing behavioral and social science foundations for HIV prevention strategies. This also would include methodologies for promoting efforts to decrease the incidence of sexually transmitted diseases (encouraging abstinence and encompassing such alternatives as condom use).

**Public education.** MSNJ shall promote and facilitate public education with regard to prevention and transmission of HIV infection specifically, in the workplace, and including the use of mass media.

**Needle and syringe exchange.** Recent studies have shown that clean needle and syringe availability reduces the incidence of HIV transmission in drug users. MSNJ supports programs to permit the availability of clean needles and syringes through needle and syringe exchange.

**Epidemiological studies.** MSNJ supports epidemiological studies of HIV infection in New Jersey residents as part of sound public health practice.

Howard A. Holtz, MD

## DOMESTIC VIOLENCE: THE NEW STANDARD OF CARE

*Domestic violence is defined as the collective methods employed to exert power and control by one individual over another in an adult domestic or intimate relationship.*

**Dr. Holtz is associate chair, Department of Medicine, Saint Barnabas Medical Center, Livingston, and associate clinical professor of medicine, UMDNJ-New Jersey Medical School, Newark.**

Physicians always have worked in the interface of the public and private sectors. Doctors in the information age must be particularly skillful, tailoring the latest media or Internet health headline to the individuals in their practice. Nowhere is this challenge to health professionals more formidable than in the epidemic of domestic violence.

Historically, domestic violence is the quintessential family secret; but in the last 20 years, it has flooded the public consciousness. Attitudes are changing from hear no evil, see no evil, to viewing domestic violence as a malignant social

and public health problem that everyone has a responsibility to eliminate. Health professionals have enormous potential to translate public policy statements, advocating zero tolerance of domestic violence into prevention and safety for their patients.

Domestic violence is defined as the collective methods employed to exert power and control by one individual over another in an adult domestic or intimate relationship. It may take the form of physical abuse, emotional abuse, sexual abuse, economic control, or social isolation of the victim.<sup>1</sup> Ninety-five percent of victims are women.<sup>2</sup> In terms of prevention, this means being female is a highly sensitive screening criterion. Domestic violence affects women of all socioeconomic classes, races, and ethnic backgrounds. There are no geographic havens; every small town, farming com-

munity, suburb, and city in the United States has a domestic violence population. An estimated two to four million American women are battered by husbands or partners every year, which makes domestic violence one of the most important public health problems facing women in this country.

In a recent survey of women in a large primary care practice, 5.5 percent experienced domestic violence in the preceding year.<sup>3</sup> One woman in five had experienced domestic violence sometime in her adult life. Abused patients tended to be younger (less than 35 years) and were more likely to be single, separated, or divorced. Abused patients had higher somatization, anxiety and depression scores, more suicide attempts, and lower self-esteem. Drug and alcohol abuse were more common in abused women and their partners. Abused women reported an



*An estimated two to four million American women are battered every year, which makes domestic violence one of the most important public health problems facing women in this country.*

**Table. Screening questions to identify domestic violence.**

1. Within the last year, have you been hit, slapped, kicked, or physically hurt by someone?
2. Within the last year, has anyone forced you to have sexual activities?
3. Since you've been pregnant, have you been hit, slapped, kicked, or otherwise hurt by someone?
4. What happens when you and your partner fight or argue?
5. Does your partner ever lose his temper? What happens when he does?
6. Is your boyfriend (partner) jealous or possessive of your time? Does he lose his temper? What happens when he does?
7. Do you ever feel afraid of your partner?
8. Are there times when you don't feel safe at home?

#Questions 1-3 are the Abuse Assessment Screen.<sup>8</sup>

average of three more symptoms than women who were not abused. Clinical presentations associated with domestic violence are illustrated in the Figure.

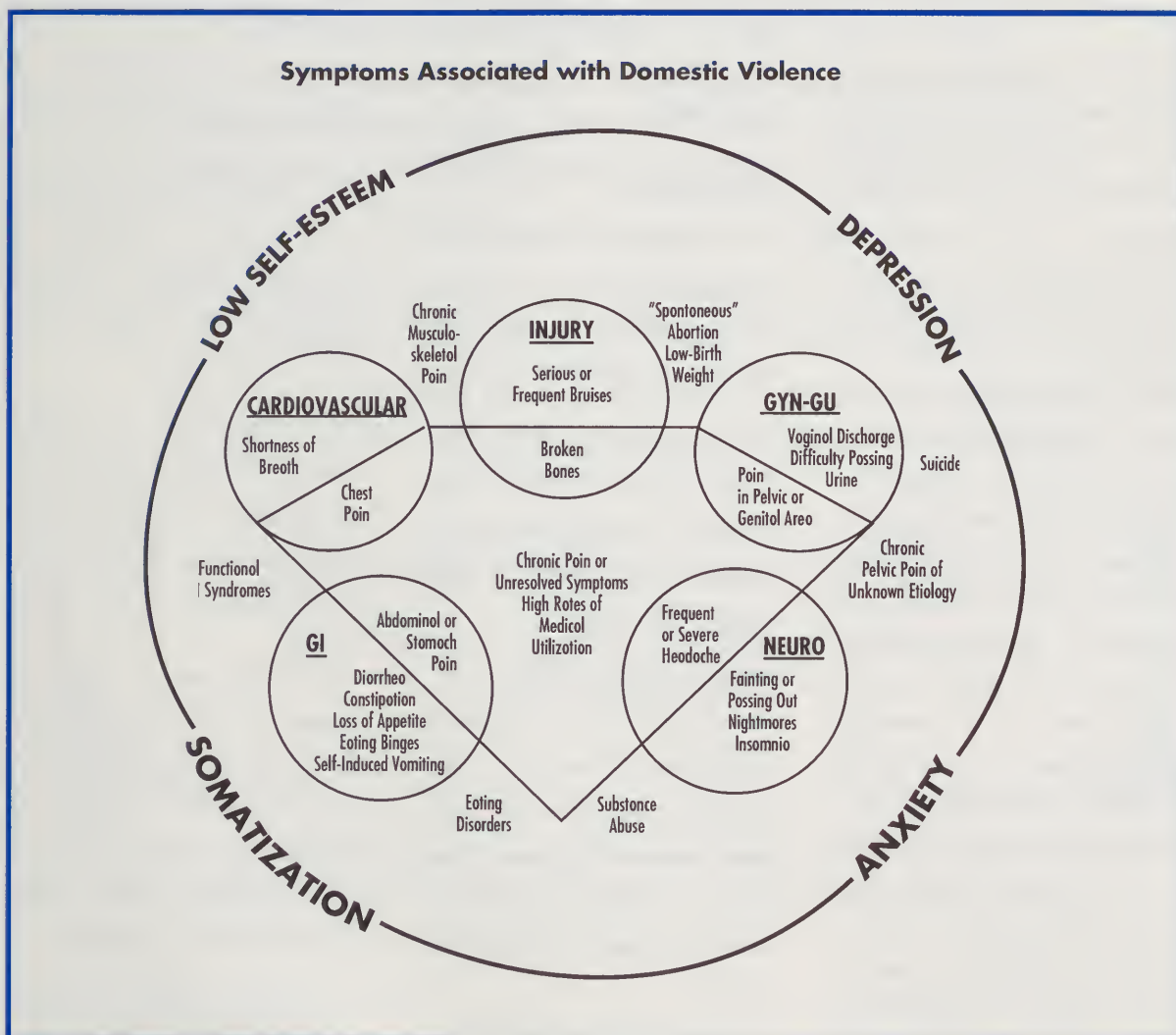
While clinical characteristics of domestic violence victims may be useful in identification, the new standard of care is to screen all women who come to any health care setting. The prevalence of domestic vio-

lence and the more than 1,200 community resources available nationally to assist battered women justifies routine screening. This standard of care is supported by many organizations including the American Medical Association and the Joint Commission on Accreditation of Healthcare Organizations.<sup>4,5</sup> Unfortunately, many physicians still do not ask their female patients about domestic

violence when taking routine social histories.

The barriers to identifying domestic violence involve patients as well as physicians and are reviewed elsewhere.<sup>4</sup> However, many of these barriers can be overcome when the physician understands the tremendous health implications of domestic violence and appreciates screening as a necessary component of accurate and efficient diagnosis and care. Some physicians may be skeptical when the word efficient is applied to domestic violence screening.<sup>6</sup> In fact, identifying domestic violence is a very cost-effective way to care for women. Looking at the Figure, one can appreciate the quagmire of useless diagnostic testing, unnecessary referrals, and patient and doctor frustration that can occur when domestic violence is not identified. Early, accurate diagnosis by history and appropriate use of community resources for battered women can prevent their frequent and unproductive medical utilization.<sup>3</sup>

*Identifying domestic violence is a very cost-effective way to care for women. Early, accurate diagnosis by history can prevent frequent and unproductive medical utilization.*



**Figure.** Clinical presentations associated with domestic violence.

Before asking women about domestic violence, physicians should always keep in mind that this is a potentially fatal condition. Thirty percent of women murdered in the United States are killed by husbands or partners.<sup>7</sup> Women will be much

more likely to respond honestly and without risk of recrimination by the abuser if they are asked in a private, confidential setting.

What routine screening questions should be asked?

There is no reference standard that defines domestic violence, as all instruments rely on self-reports. The Abuse Assessment Screen was compared to longer research questionnaires and found to be valid and specific.<sup>8</sup> It includes a question



*Screening for domestic violence is a new standard of women's health care. Health care professionals are uniquely situated to assist battered women.*

related to pregnancy, a time when the risk of abuse is high.<sup>9</sup> A screening question that can be directed toward potential abusers, as well as victims, is, "What happens when you and your partner fight or argue?" An adolescent patient can be asked about a partner's jealousy, possessiveness, or temper, to prevent or to detect dating violence. Some physicians feel more comfortable explaining that domestic violence has become so common that they now ask all patients about it, before they ask a screening question. One or two screening questions of the physician's choice should be incorporated into the history of every female patient (Table). Once domestic violence is identified, management strategies that emphasize safety, support, and referral can be provided.<sup>10</sup>

Screening for domestic violence is a new standard of women's health care. Health care professionals are uniquely situated to assist battered women. In doing so, a private catastrophe can be prevented and a public health problem,

too long tolerated, can be addressed.

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Arthur S. McLellan, MD

## A REVIEW OF THE TREATMENT OF ALCOHOLISM

*A diagnosis of alcoholism should be based on a complete biopsychosocial evaluation including physical examination, medical and family history, and relevant laboratory studies.*

**Dr. McLellan is a retired physician; he is a member of MSNJ's Union County component.**

Alcoholism is a public and personal health problem that can be diagnosed and successfully treated. Universal screening of patients for the presence of alcoholism is urged. Alcoholism should be considered and managed as a chronic disease.

Of preventable illnesses, alcoholism is a major public health concern. The leading causes of New Jersey deaths in the 1990s in order of frequency are: diseases of the heart, malignant neoplasms, cerebrovascular disease, chronic obstructive pulmonary disease, pneumonia, influenza, unintentional injuries, diabetes mellitus, HIV infection, septicemia, and nephritis/nephrosis. Alcohol use has been identified as a component in these conditions.

**Statistics.** Twenty percent of adults who visit physicians have alcohol problems. Forty percent of a general hospital's patient population will screen positive for alcoholism and remain hospitalized an average of four times as many days as nonalcoholics. Yet, the diagnosis of alcoholism frequently is missed, and the disease progresses with eventual discovery as complications occur.

Falls are attributed to alcoholism in 17 to 53 percent of reported cases; 48 to 64 percent of deaths by fire have alcohol levels indicating intoxication.

Fetal alcohol syndrome (FAS) is among the leading causes of mental retardation; 50 to 60 percent of fatal motor vehicle crashes and other trauma are traced to alcohol intoxication as are family violence, suicide, and homicide.

Insurance company data reveal that complications of

alcoholism result in 100 percent higher costs per patient than for a patient not suffering from alcoholism. Also, expenses increase 300 percent per year for alcoholics who are not treated for this disease. Family members are similarly subject to increased medical costs with health care costs twice that of nonalcoholic families. Treatment and recovery results in a return to normal utilization and costs.

**Diagnosis.** The components of an adequate assessment and management when alcoholism is suspected include methods of establishing a diagnosis, a degree of severity, and a relevant treatment plan based on need. The insidious and silent nature of this addiction speaks to the need for screening all patients as part of a periodic patient evaluation program.

A diagnosis of alcoholism should be based on a complete



*Total abstinence has been the traditional goal of treatment. However, any modification of an existing pattern of abuse and its related manifestations is a worthy goal.*

biopsychosocial evaluation including physical examination, medical and family history, and relevant laboratory studies.

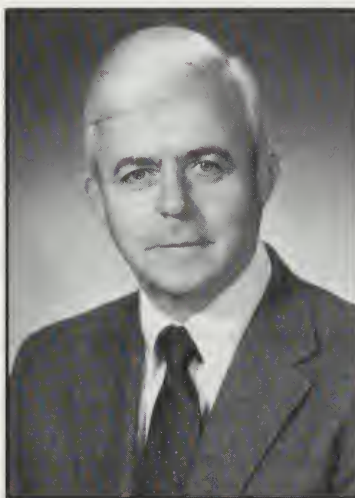
Various physical stigmata of alcoholism should be recognized, characteristic historical events of the patient and family must be noted, and relevant laboratory studies should be evaluated.

Laboratory studies, although not definitive, can be helpful in assessing the total picture. Specific markers that may be present include an increase in the serum gamma glutamyl transferase and an increase in the mean corpuscular volume reflecting, in turn, liver damage (although not exclusive to alcohol) and nutritional deficiency.

### **Screening methods.**

Screening instruments help focus data collection and are time and cost effective. There are many to choose and they vary from simple to complex. The following methods have been well accepted and have a high reliability.

A structural clinical interview administered by a clinician for 15 minutes, and reflecting definitive criteria for diagnosis can be found in the *Diagnostic and Statistical Manual for Mental Disorders (DSM3R)*. Studies have shown that the test



David I. Canavan, MD, medical director, MSNJ Physicians' Health Program

correctly identified 75 percent of alcoholics and 96 percent of nonalcoholics.

CAGE is a mnemonic device and should not take more than one to four minutes to review. It may be self-administered or administered by a clinician integrating the questions into a

general history. The CAGE components are: C: attempt to cut down on use; A: annoyance at criticism about use; G: guilt about use; and E: use of eye opener. An affirmative answer to two components indicates the probability of a problem and further evaluation is indicated.

**Treatment.** Patient confrontation by a physician for a diagnosis of alcoholism and the need for treatment has a profound effect in addressing denial. Although this may not occur at once, it frequently is cited by the recovering alcoholic as the motivating factor that led to accept treatment.

The choice of treatment is dependent on many variables and correlates directly with the severity of the problem.

Acute toxicity from alcohol must be managed with care and awareness of a potential fatal complication of the withdrawal syndrome. Following this phase of treatment, the management of alcoholism must be related to need as correlated with specific criteria.

Reference should be made to patient placement criteria for treatment from the book, *Psychoactive Substance Use Disorder*, published by the American Society of Addiction Medicine, that describes criteria by which levels of care can best be determined.

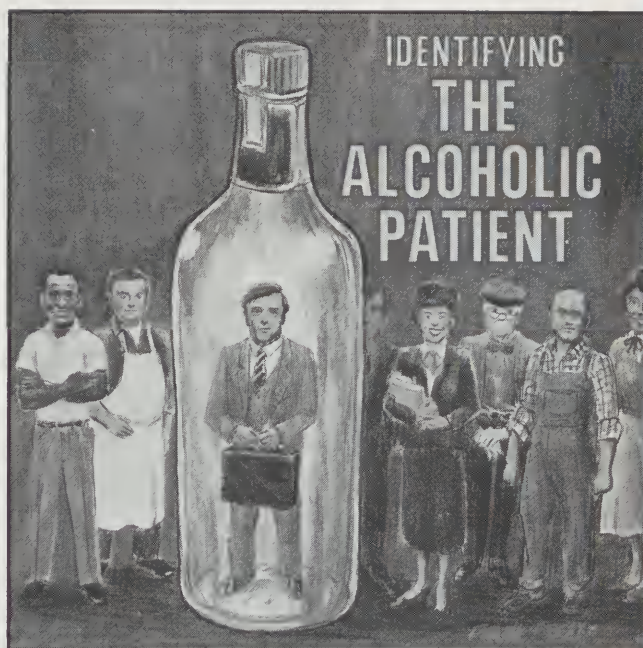
**Recovery.** A vital aspect of all recovery programs must include an early involvement with the fellowship of Alcoholics Anonymous (AA).

Total abstinence has been the traditional goal of treatment. However, any modification of an existing pattern of abuse and its related manifestations also is a worthy goal and may be a step toward full recovery. As the course of the progression of the disease may vary with wide swings of excessive use and periods of control, the recovery process also may vary with alternate phases of success and failure. This pattern of recovery and relapse is not unlike most chronic disease. The perception of alcoholism (and other substances of abuse) should be considered, therefore, as any other mainstream disease.

**Discussion.** Medical school education, as well as residency training, does not view substance abuse as an important component of the main core curriculum. The opportunity of establishing a

diagnosis early in the course of disease is a given that is well accepted. If alcoholism is not recognized early, it may surface eventually as the process continues with secondary medical complications requiring care in the emergency department, intensive care unit, and extended hospital care. Not only does early recognition and treatment make sense medically, but clearly it is cost and life saving.

The challenge in the management of alcoholism is to increase the awareness of the possibility of the disease. The goal is the prevention of the progressive complications of untreated disease. Success will



occur when the public and health professionals are well informed and when levels of treatment are determined according to specific indicators.

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## The Power of Drink

Two slim volumes have recently been published that chronicle the devastating effects of alcohol. The accounts in each of these books—*Drinking: A Love Story* by Caroline Knapp (Dial Press) and *Terry: My Daughter's Life-and-Death Struggle with Alcoholism* by George McGovern (Villard Books)—prove the powerful influence of alcohol and the tremendous difficulties in countering such a power. Knapp's beautifully written tale details her affair with alcohol; interspersed throughout the story are the real facts: 15 million Americans suffer from the disease of alcoholism each year. McGovern's honest account of his daughter's death from the use of alcohol dramatizes the cruel reality of how alcoholics try to deal with the disease and how families of alcoholics deal with the patient.

Both books deserve our attention, though Knapp's book will have a more lasting effect because of its style, clarity, and use of the English language to portray the brutality of alcoholism.—**GH**

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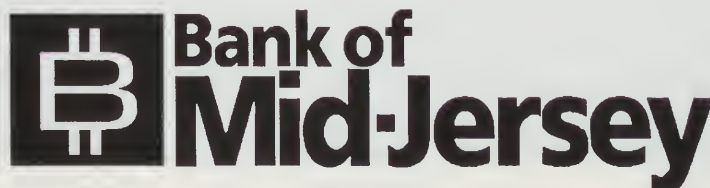
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# COMMENTARY

## The MSNJ House of Delegates at work

The dust has settled and the 230th Annual Meeting of the Medical Society of New Jersey (MSNJ) is over. The 1996 MSNJ House of Delegates analyzed 14 reports and studied and reported on 70 resolutions, significantly more than in previous years.

MSNJ President Anthony P. Caggiano, Jr, painted a picture of the condition of health care in New Jersey. "There is tremendous turmoil in the profession. There is a lot of confusion, coercion, and change." To this end, the House of Delegates played a vital role in bringing to the forefront the prominent issues for today's physicians and health care community.

The following account highlights the major actions of the 1996 House of Delegates from the resolutions presented to it from county medical societies and individual delegates.

**Resolution #16: Medical Savings Accounts.** Introduced by the Essex County Medical Society, this resolution favors medical savings account (MSA) laws. As explained by Howard D. Slobodien, MD, "An MSA is a specified amount of money set aside, either by an employer (including governments) or by an individual, alone or as part of a family group. This fund would be used de novo to pay for routine medical expenses; subsequent expenses would be covered by an insurance company with a deductible equal to the original amount, and at a low premium because of the high deductible. Instead of third parties being the payers for health care, the patient would be both the giver and the recipient of these services." Such laws have been enacted in many states—Arizona, Colorado, Idaho, Illinois, Michigan, Mississippi, Missouri, New Mexico, Utah, Virginia, and West Virginia.

The House of Delegates adopted the following resolution: Resolved, that MSNJ study what other states have accomplished in



the area of authorizing the use of MSAs and report to the MSNJ Board of Trustees for possible implementation of a New Jersey initiative.

Resolution #18: Payment for Indigent Services; Resolution #39: Uncompensated Care; Resolution #41: Establishment of Reimbursement for Physicians by the State Uncompensated Care Fund. Although introduced separately, the House of Delegates considered these three resolutions together. Charles M. Moss, MD, chair of the Council on Communications, pointed out that physicians care for indigent patients and devote time and medical and legal responsibilities to these patients. Many health care professionals feel that to solve this crisis of charity care, legislation is necessary to create government subsidized insurance programs.

After careful consideration, the House of Delegates adopted the following substitute resolutions: Resolved, that MSNJ support legislation and regulatory efforts to enroll the indigent population in a government-subsidized insurance program; and be it further Resolved, that MSNJ redouble its public relations efforts to educate the Legislature and

the public concerning the magnitude of the uncompensated care that always has been provided by physicians, currently estimated to be

\$700 million in

New Jersey;

and be it further

Resolved, that MSNJ

support legislation that would include fair and reasonable reimbursement to physicians who provide services to indigent patients.

Resolution #19: Guardianship. Concerned with the lengthy process for the appointment of a guardian for the

incompetent patient, Essex County Medical Society submitted this resolution. To transfer such patients to a nursing home or other appropriate residential care facility, the hospital must assume the responsibility for initiating the application for

appointment of a guardian by the Superior Court of New Jersey. Often, this process can take up to several months. To help expedite this process, the House of Delegates adopted the following resolution: Resolved, that MSNJ join with the New Jersey Hospital Association to effect a change in the guardianship process that will

## COMMENTARY



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MSNJ President Dr. Caggiano

allow for the expeditious appointment of guardians for mentally incompetent patients of hospitals or otherwise per-

mit the transfer of mentally incompetent patients to a nursing

home or other appropriate residential care facility pending the appointment of a guardian of such patients.

**Resolution #21: Payment for Services by Insurance Companies.** Past-president William E. Ryan, MD, proposed a resolution concerning payment for services by insurance companies. Dr. Ryan explained that insurance companies demand 100 percent premium payment from subscribers on a specific date, with a grace period of 10 to 30 days, or cancellation of the subscribers' coverage. To mirror current proposed legislation, the House of Delegates adopted the following resolution: **Resolved**, that it should be mandatory for insurance companies to pay physicians and hospitals within 30 days of receipt of an itemized bill or pay a significant penalty and interest plus fees.

**Resolution #58: Managed Care Authorizations/Denials.** Submitted by Mercer County Medical Society, this resolution addresses preauthorization by managed care companies.

MSNJ President Caggiano believes, "Physicians need the freedom to prac-

tice medicine without undue bureaucratic or unwarranted barriers." To achieve this, managed care companies need to have prompt and accurate authorization for physician services.

Commissioner of Health Len Fishman in his comments to MSNJ stated, "Well-run HMOs can contain costs, coordinate care, provide preventive and primary care, and promote accountably through quality outcome measures."

With this in mind, the House of Delegates adopted the following resolutions: **Resolved**, that MSNJ request the enactment of a law to require that once a procedure or surgery is scheduled, the managed care company should give a denial or authorization within one week of notification by the physician's request or the institution's request; and be it further **Resolved**, that MSNJ pursue regulations that would require timely processing of preauthorization for a procedure or treatment; and be it further **Resolved**, that MSNJ pursue regulations that would prohibit the withdrawal of preauthorization after the service has been rendered.

The 1996 House of Delegates has put in place policy for its physician-members and the patients they serve. The Table presents the remaining resolutions that were adopted by the House of Delegates.

For a complete copy of the proceedings of the 1996 Annual Meeting, contact MSNJ, 609/896-1766.

## COMMENTARY

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Table. Resolutions Adopted by the MSNJ 1996 House of Delegates.

<u>No.</u>	<u>Title</u>	<u>Resolution</u>
#1	Publication of Research Funded by the Tobacco Industry	Resolved, that MSNJ petition the AMA to modify its policy, 490.940, to read, "The AMA strongly discourages all medical schools and their parent universities from accepting research funding from the tobacco industry; and urges all scientific publications to decline such funded research for publication."
#2	Preservation of Political Advocacy by Nonprofit Organizations	Resolved, that MSNJ petition the AMA Board of Trustees to oppose a federal initiative that would impose restrictions on advocacy activities of federal grantees that preclude them from both utilizing private funds for advocacy activities as well as delivering government-funded services.
#3	DOH Complaint Bureau Advertising	Resolved, that MSNJ advertise in the various media by multiple notices the existence of DOH's complaint bureau.
#5	Public Relations Releases for County Societies	Resolved, that in an effort to raise public awareness and support of our goals, MSNJ make available to its component county societies general public relations releases for their use at no extra cost.
#6	Routine AIDS Testing	Resolved, that MSNJ urge all New Jersey hospitals to adhere to Centers for Disease Control (CDC) guidelines that state, "Hospitals with an HIV prevalence rate of at least 1 percent or an AIDS diagnosis rate of equal to or greater than 1 per 1,000 discharges should adopt a policy of offering HIV counseling and testing routinely to patients ages 15 to 54 years of age"; and be it further Resolved, that the AMA Delegation bring this resolution to the AMA at its 1996 Annual Meeting.
#8	Medicare Reimbursement	Resolved, that MSNJ urge the AMA to rescind any policy that supports lower Medicare reimbursement in return for government promises of future increases; and be it further Resolved, that the AMA Delegation bring this resolution to the 1996 Annual Meeting.

<u>No.</u>	<u>Title</u>	<u>Resolution</u>
#9	State Representation in the AMA	Resolved, that MSNJ urge the AMA Federation Study Project Team, through the AMA Delegation, to cease and desist from any attempts to weaken the state delegations in the AMA House of Delegates.
#13 #50	Physicians and Jury Duty Physician Exemption from Jury Duty	Resolved, that MSNJ seek an amendment to the New Jersey statute that permits physicians in active clinical practice to be exempt from jury duty because of their unique relationship and responsibilities to their patients.
#17	HCFA Correct Coding Initiatives	Resolved, that MSNJ request the AMA to petition HCFA to make Medicare coding manuals and updates on coding data and requirements readily available to all physicians at no cost.
#22	Sole Obligation of Insurance Company	Resolved, that it is the sole obligation of the insurance company to instruct, educate, and assist its subscribers in proper use and benefits of the plans composed and sold by it.
#23	Posting of Insurance Company Restrictions and Limitations	Resolved, that physicians and hospitals be granted the privilege of informing their patients of restrictions and limitations regarding patient care mandated by the subscribers' insurance company.
#24	Gag Rule	Resolved, that MSNJ support regulatory efforts and/or legislation that would restrict HMOs from presenting contracts to physicians that prohibit doctors from advising patients of all treatment options.
#25	Use of the Gag Rule To Prohibit Physician-to-Patient Discussion	Resolved, that MSNJ work to enact legislation or regulation to prohibit any New Jersey licensed health insurer from enforcing the gag rule against any New Jersey physician.
#28	Flexner Report II	Resolved, that MSNJ request the AMA to urge an independent organization to conduct an objective and comprehensive evaluation of the structure, function, and curriculum of United States medical schools, and that the AMA promulgate appropriate recommendations for change and improvements of United States medical schools based on the report of the independent organization.



<u>No.</u>	<u>Title</u>	<u>Resolution</u>
#30	Medication Expiration Dates on Prescription Labels	Resolved, that MSNJ petition the New Jersey Board of Pharmacy to require expiration dates on prescription labels.
#32	Creation of a Special Category of Current Procedural Terminology (CPT) Related to Issues of Withholding and Withdrawing of Medical Treatments at the End of Life	Resolved, that MSNJ request the AMA to encourage the creation of a separate CPT code regarding a reimbursable consultation category dedicated exclusively to the discussion of advanced directives and end-of-life decisions.
#35	AMA and Medical Societies Representing Members Against Their Employers	Resolved, that MSNJ forward a request to the AMA to continue to seek congressional relief from antitrust laws, as a high priority to allow the AMA and its component societies to represent members.
#36	Deselection of Physicians; Fairness to Patients	Resolved, that MSNJ work with the New Jersey state commissioner of health to protect patients from HMOs unfairly deselecting their physician and to provide adequate time for the insured patient to choose other health insurance if so desired.
#37	Patient Protection Act	Resolved, that MSNJ continue its effort in a public relations campaign for support of the Patient Protection Act to the public and the representatives in the Assembly and Senate.
#38	Coverage for Flexible Sigmoidoscopy	Resolved, that the efficacy of flexible sigmoidoscopy and other screening programs be investigated by the Council on Public Health; and be it further Resolved, that MSNJ report this information to the appropriate state agencies for implementation in insurance policy coverage.
#43	Subacute Rehabilitation Facilities	Resolved, that MSNJ in conjunction with the New Jersey Medical Directors Association evaluate the needs of subacute care in the long-term care setting and make appropriate recommendations to the appropriate agencies.

<u>No.</u>	<u>Title</u>	<u>Resolution</u>
#47	Physician Compensation Telephone Call Codes	Resolved, that MSNJ endorse the remuneration of CPT 99371, CPT 99372, and the creation of a third code, CPT 99373 for telephone consultation with a patient and/or close relatives at a reasonable rate of reimbursement.
#49	Mandatory Electronic Billing	Resolved, that MSNJ oppose the mandating of electronic billing for physician offices; and be it further Resolved, that MSNJ petition HCFA and insurance companies to process claims within 30 days whether electronic or manual billing is used.
#51	Centralization of Physician Credentials	Resolved, that MSNJ continue its efforts to have MRAC serve as a voluntary centralized clearing-house for confirming physicians' credentials.
#54	Hold Blameless Clause	Resolved, that MSNJ petition the commissioner of health and the commissioner of insurance to bar hold harmless clauses requiring indemnification in HMO/physician contracts.
#56	Protection of DEA Numbers	Resolved, that MSNJ strongly oppose the practice of printing DEA numbers on all medication labels, and notify the state Board of Pharmacy of MSNJ's position; and be it further Resolved, that MSNJ also demand that no insurance company may require that a DEA number be required for filling a noncontrolled prescription.
#57	HMO Solicitations of Medicare Beneficiaries	Resolved, that MSNJ adopt, as a focus for its public relations and media campaigns, efforts to afford senior citizens information about how to choose health plans that have their best interests in mind.
#61	AMA National Leadership Conference	Resolved, that MSNJ convey to the AMA its concerns about the decreased quality of the AMA National Leadership Conference regarding content and meeting facilities.



<u>No.</u>	<u>Title</u>	<u>Resolution</u>
#62	Organized Medicine's Role in Assuring Safeguards to the Environment	Resolved, that MSNJ assist local and state officials in the investigation of cancer outbreaks and request the Legislature to assure our New Jersey citizens that such matters will be properly investigated and corrected; and be it further Resolved, that MSNJ's Council on Public Health review the state Department of Health activities regarding the Toms River inquiry and report its findings in <i>New Jersey MEDICINE</i> .
#64	New HCFA Clinical Laboratory Guidelines Requiring ICD-9 Codes and Discouraging Screening Tests and Profiles	Resolved, that MSNJ request the AMA to petition HCFA to delay and modify these new clinical laboratory reimbursement rules requiring: ICD-9 diagnoses to justify tests on HCFA 1500 forms; carriers to decline payment for screening tests such as a PSA; and carriers to decline payment for screening panels such as a SMA 12 electrolytes.
#65	"Fifth Digit" Coding Requirements Modify Medicare ICD-9	Resolved, that MSNJ request the AMA to petition HCFA to amend its rules so that ICD-9 fifth digit coding is not required for reimbursement until after three visits to that physician for that condition.
#67	Unlicensed Assistive Personnel in Hospitals	Resolved, that MSNJ urge both the state Department of Health and the state Board of Nursing to exert greater control over the training and functions of unlicensed assistive personnel, that standards of training and responsibility be established, and that a method be devised to easily identify such personnel from other licensed professionals; and be it further Resolved, that MSNJ instruct its AMA Delegation to bring this problem to the attention of the AMA-OMSS.

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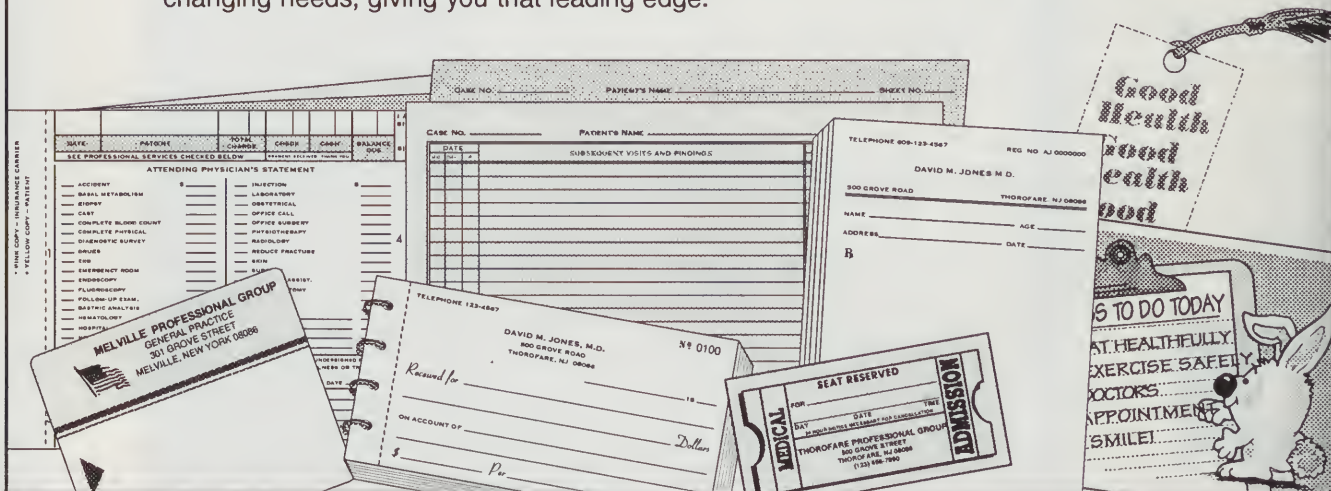
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## DO YOU SUPPORT A GOVERNMENT-SANCTIONED NEEDLE-EXCHANGE PROGRAM?

Jim McGarry

*Advocates for needle-exchange programs and the decriminalization of syringe distribution on demand confuse naive, wishful thinking for sound, logical reasoning.*

As everyone should know, drug addiction is one of the truly horrific problems of modern civilization. The craving for drugs will drive addicts to child neglect and abuse, burglary, criminal assault, and prostitution. Drug addicts are driven to prey on neighbors and into activities that no sane individual would con-

template. Intravenous drug users also share the same hypodermic syringes that other addicts use, and thereby contribute to the spread of diseases endemic among junkies, pushers, and prostitutes. Those diseases include killers such as hepatitis and AIDS.

That predilection for risky behavior, and disinclination to take commonsense precautions, has earned for New Jersey the dubious distinction of being the state with the highest percentage of AIDS cases attributable to illegal drug use. Those habits also have doomed thousands of children and other non-addicts to a slow and painful death from AIDS. The toll in suffering and financial loss is beyond calculation.

Concerned private individuals and government officials have recognized the need to help prevent this terrible scenario, and alleviate suffering in those

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Dawn Day, PhD

*Making it possible for injecting drug users in New Jersey to get access to sterile needles would save thousands of lives and uncountable human misery.*

A major cause of the spread of HIV/AIDS is dirty needles. Making it possible for injecting drug users to get access to sterile needles would save thousands of lives and uncountable human misery. A happy, additional consequence would be that hundreds of millions of dollars in medical treatment costs also would be avoided.

So why in New Jersey do we make it difficult or impossible for persons who inject drugs to get sterile needles? Some people, including Governor Christine Todd Whitman, say they are concerned about sending a double message. But a double message is unavoidable. When a person is suffering from an overdose, we rush that person to a hospital and give them the best medical care. We do not say to the drug user's family and friends, "Sorry, we cannot give your family member life-saving medical care because it would send the wrong message."

Getting sterile needles to persons who inject drugs is about medical care and saving lives. In fact, it is about sending the message that human life is valuable.

In our society, medical interventions go beyond pills, bandages, and surgery. In the name of public

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## McGarry

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who already are infected with the disease. Governor Christine Todd Whitman, for example, recently urged then Senate Majority Leader Bob Dole and House Speaker Newt Gingrich to support President Bill Clinton's supplemental budget request for \$52 million for state AIDS drug programs. Also, Governor Whitman reconvened an advisory panel to provide her with expert advice on how to make best use of the state's resources in the fight against the disease.

The members of the Governor's Advisory Council on AIDS, as well as experts from a variety of fields, have identified numerous ways to prevent the spread of AIDS and to treat infected patients. Among the weapons currently available, educational and health promotional programs are known to be effective, as are new medications, including anti-infectious agents and the protease inhibitors. In addition, some well-intended individuals and activists have advocated that the government sanction the use of so-called needle-exchange programs and decriminalize the over-the-counter distribution of hypodermic syringes on demand. Needle-exchange programs permit drug addicts to swap used, and presumably infected, needles for new syringes, in the hope that they will use the clean needle once, and not share it with other drug addicts. Moreover, needle-exchange programs attempt to provide the addict with counseling and education in risk avoidance, as well as sterile cotton, and clean bottle cap "cookers."

Obviously, these programs are predicated on the assumption that drug addicts are capable of making responsible, well-informed decisions regarding their use of illicit drugs and other illegal activities. In addition, the studies most often cited in support of claims as to the efficacy of these programs lack control groups, involve very limited numbers of test subjects, and rely on self-reporting of critical activities by sick and unstable test populations. Absent a well-

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health we remove asbestos, cover over lead-based paint, and purify water. Given the medical consensus that has emerged on the effectiveness of sterile needles as a way of avoiding the spread of drug-related HIV/AIDS, it is difficult to see the denial of access to sterile needles as anything other than the denial of access to a life-saving medical intervention.

In the history of modern medicine in the United States, I am aware of only one other instance where a life-saving medical intervention involving a deadly infectious disease was deliberately denied to a group of people. That instance is the now infamous case of the Tuskegee syphilis experiment. The originators of the "experiment" justified their activity by saying they wanted to study the course of untreated syphilis. The unfortunate victims of this study were a 400 black men in Tuskegee County, Alabama, who were denied medical treatment for their syphilis from 1932 when the study began until they died or, if they lived, until 1972, when the "experiment" was exposed and stopped.

In the age of AIDS, people who advocate the denial of access to sterile needles should give careful thought to what they are saying and the company they are keeping.

The nature of the argument used to deny federal funding for needle-exchange programs also is worth exploring. According to federal law, needle exchanges and other programs that would make sterile needles available to injecting drug users cannot be financed by federal dollars until it has been shown that such programs do not encourage the use of illegal drugs.

Since 1991, six different United States government-funded reports have concluded that needle-exchange programs do not increase drug use. In the face of this overwhelming evidence, the federal government still refuses to release funds for sterile needle programs. Ignoring their scientific advisors, key

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reasoned scientific rationale, supporters often postulate that if implemented on a broad scale, only those members of the population in the immediate high-risk category would be affected, and, in any case, we cannot afford not to do everything possible to fight this plague.

In terms of the development of public policy, I believe that advocates for needle-exchange programs and the decriminalization of syringe distribution on demand confuse naive, wishful thinking for sound, logical reasoning. Moreover, if implemented on a large scale, these programs would not only fail to help those most in need, they would seriously jeopardize the safety and well-being of those that are not currently in danger. There are a number of reasons why I take this position.

First, and from an ethical perspective, we should remember that the actions we take ought to be right in themselves, and not because some good will hopefully result. Programs that facilitate self-destructive and illegal activities are manifestly unethical, and are to be avoided.

Secondly, it is an inescapable fact that these programs present a contradictory and confusing message insofar as the use of dangerous and illegal drugs are concerned. Simply put, the unregulated sale or distribution of drug paraphernalia implicitly encourages the use of illegal drugs. Any law that might encourage the use of these drugs, especially among our young people, would be a very bad law.

Governor Whitman, as well as former Governor Jim Florio and Newark Mayor Sharpe James, have adopted this position as part of their opposition to these programs. Governor Whitman, for example, argues that the free distribution of hypodermic needles would "send a mixed signal. It would tacitly encourage illegal drug use." Moreover, the Newark Branch of the National Association for the

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## Day

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officials assert that not all the evidence is in. Examining this situation, it is hard to escape the unpleasant conclusion that some misguided political consideration and not scientific evidence is governing federal decision making in this life-and-death situation.



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Having informed the reader of the massive scientific evidence showing that the distribution of sterile needles does not increase drug use, my presentation as a social scientist is at an end. But as a religious person, I must raise a question about the morality behind the criteria being applied.

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## McGarry

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Advancement of Colored People (NAACP) and the Governor's Council on Alcoholism and Drug Abuse have voted to oppose these programs on much the same grounds.

Third, it has been shown that these programs foster a dangerous environment in the neighborhoods in which they operate. For example, pharmacies in some areas of Connecticut, where over-the-counter distribution of syringes (without prescription) is permitted, reported that addicts would occasionally inject illegal drugs while in the pharmacy. The used and possibly infected needles then were discarded on the floor of the pharmacy, or on the sidewalk outside. Moreover, addicts were found to congregate in the area around the needle distribution sites, thereby creating a nightmarish scenario for vulnerable senior citizens and parents with young children.

This dangerous situation is exacerbated in that drug addicts from areas where public opposition would not allow such distribution centers to operate are drawn to neighborhoods that do permit such practices. It should come as no surprise that the majority of local elected officials, as well as religious and secular leaders cannot allow such a situation to exist.

Needle-exchange programs and the decriminalization of over-the-counter distribution of hypodermic syringes involve very grave risks for a society that cannot afford to lose the war on drugs. More to the point, the benefit of these programs, even to a limited segment of the overall population, has not been demonstrated in convincing fashion. For these reasons, I believe it is imperative that elected officials and other leaders continue to oppose these programs, and support implementation of other strategies that have proved value.

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How can it be ethical to deny life-saving medical care to one person in an attempt to influence the behavior of another? Would we ever consider denying medical treatment to John, an alcoholic, until we could prove that John's treatment for kidney disease will not cause someone else to become an alcoholic? Would we ever consider denying medical care to Mary, a smoker, until we could prove that Mary's treatment for lung cancer will not cause someone else to start smoking?

The fact that drug use is illegal cannot be used to justify this strange federal criteria. Under criminal law, we punish people for the crimes they themselves have committed sometime in the past. We do not punish people for crimes someone else might commit sometime in the future.

Clean needle programs save lives. We must make it possible for such programs to exist. The people of America favor clean needle programs. A recent national survey funded by the Kaiser Family Foundation found that two-thirds of Americans favor needle exchange as a means of slowing the spread of HIV/AIDS.

The Medical Society of New Jersey and the many other medical professional organizations that have passed resolutions in favor of clean needle programs need to continue to speak out forcefully. Together we can make the thin strata of political leaders who oppose needle exchange realize that they are out of step both with the common sense of the American people and the scientific research of the United States and international medical communities.

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**NJM**

### Basic facts on drug-related AIDS in New Jersey

- New Jersey ranks first among all the states in terms of the proportion of AIDS cases among adults and adolescents that are related to injection drug use.
- New Jersey ranks second among all the states in terms of the number of injection-related AIDS cases since the beginning of the AIDS epidemic.
- By the end of 1995, over 15,500 New Jersey residents age 13 and over were living with injection-related AIDS or had died from it.
- The injection-related AIDS epidemic among African-Americans in New Jersey truly is a health emergency. Although African-Americans are less than 15 percent of the population of New Jersey, they account for over 60 percent of new injection-related AIDS cases in 1995.
- By the end of 1995, over 9,600 New Jersey African-Americans age 13 and over were living with injection-related AIDS or had died from it.
- It costs over \$120,000 to provide medical treatment for a person with HIV/AIDS. The cost of treating just the 1,900 persons diagnosed with injected-related AIDS in 1995 in New Jersey will be over \$230 million. Funding a needle exchange that would save many lives would cost roughly the same as the medical treatment for one person with HIV/AIDS.
- There are bills in both houses of the New Jersey Legislature to make clean-needle programs possible: Senate Bill S-463 sponsored by Senator Wynona M. Lipman and House Bill A-1968 sponsored by Assemblypersons Wilfredo Caraballo (D-Essex) and Loretta Weinberg (D-Bergen).



## *Here's what we are covering in September 1996*

- ⇒ **How is New Jersey paving the way for organ transplantations?**  
Read about New Jersey's comprehensive transplant program that reaches out to all residents of the state.
- ⇒ **What are the trends in medical malpractice today?**  
MSNJ Deputy Executive Director Neil Weisfeld reviews current medical malpractice cases in the Garden State and how they affect health care professionals.
- ⇒ **How can we end the epidemic of violence?**  
Dr. Donald Louria discusses the need to control and cope with societal violence.
- ⇒ **What is the latest surgical treatment for epilepsy?**  
Robert Wood Johnson Medical School professor Dr. Richard Lehman analyses the latest data on epilepsy.
- ⇒ **What do New Jerseyans know about AIDS?**  
Dr. Jane Miller from the Institute of Health, Health Care Policy, and Aging Research discusses the results of a study of New Jersey adults and their knowledge of AIDS.
- ⇒ **Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.**



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# calendar

## UPCOMING PROGRAMS

### **Orofacial Pain and TMD**

September 4, 1996  
UMDNJ, Newark  
201/982-6561

### **Honors for Dr. Jacob Churg**

September 8, 1996  
Barnert Hospital, Paterson  
201/977-6600

### **Tuberculosis**

September 9, 1996  
UMDNJ, Newark  
201/982-4267

### **Restorative Nursing**

September 11-12, 1996  
Gov. Morris Hotel, Morristown  
201/539-7300

### **Cardiovascular Disease Treatment**

September 19, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Herbal Medicines in Nigeria**

September 26, 1996  
George F. Smith Library, Newark  
201/982-6293

### **MCMS Hall of Fame Dinner**

September 28, 1996  
Hyatt Regency, Princeton  
609/882-1048

### **Laparoscopy and Hysteroscopy Surgery**

September 28, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Sesquicentennial Party**

October 1996  
Camden County Medical Society  
609/772-0800

### **Marketing Services in Managed Care Arena**

October 2, 1996  
Holiday Inn, Princeton  
609/452-2400

### **Health & Fitness Expo**

October 5-6, 1996  
Fairleigh Dickinson University  
201/646-4379

### **Sports Medicine Seminar**

October 9, 1996  
MSNJ, Lawrenceville  
609/896-1766

### **Dermatology for Primary Care**

October 17, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Mantoux TB Testing Course**

October 18, 1996  
UMDNJ-Newark  
201/982-4267

### **Physicians and the Media**

October 19, 1996  
American Society of Journalists  
212/997-0947

### **Plastic Surgery**

October 19, 1996  
Scheie Eye Inst., Philadelphia  
215/662-8100

### **Dermatology for Primary Care**

October 24, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Bioactive Lipids**

October 28, 1996  
School of Osteopathic Medicine  
UMDNJ, 609/566-6000

### **Classical Medical Systems in India**

October 31, 1996  
George F. Smith Library, Newark  
201/982-6293

### **Pharmacology of Eicosanoids**

November 4, 1996  
School of Osteopathic Medicine, Stratford  
UMDNJ, 609/566-6000

### **Ob/Gyn Issues**

November 7-9, 1996  
Lake Buena Vista, Florida  
201/982-4267

### **Chronic Pain Management**

November 16, 1996  
RWJMS, New Brunswick  
201/982-4267

### **Renaissance Medical Students**

November 21, 1996  
George F. Smith Library, Newark  
201/982-6293

### **New Targets in Stroke Research**

November 22, 1996  
School of Osteopathic Medicine, Stratford  
UMDNJ, 609/566-6000

### **Conference on CME**

November 26, 1996  
MSNJ, Lawrenceville  
609/896-1766

### **Tuberculosis and the Law**

December 2, 1996  
UMDNJ, Newark  
201/982-4267

### **AMA Interim Meeting**

December 8-11, 1996  
Atlanta, Georgia  
312/464-5000



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## Cardiology Update

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Program Directors: Bernard L. Segal, M.D., and Michael S. Feldman, M.D.

**September 4, 1996    Bedside Diagnosis of the Cardiac Patient - Part I**  
**Moderators: Bernard L. Segal, M.D.**  
**Michael S. Feldman, M.D.**

Patients will be presented with interesting clinical findings. Carotid and jugular venous pulsation will be analyzed. The precordium will be palpated to determine abnormal impulses. Heart sounds and murmurs will be interpreted in light of the patient's symptoms and the clinical findings. Appropriate patients will be presented including those with abnormal splitting of the second heart sound, opening snaps, third and fourth heart sounds, ejection clicks and mid-systolic clicks. Stethophones will be available at each seat so that the audience will be able to hear and interpret these findings. Appropriate echocardiograms will be shown.

### **Upcoming programs:**

- |                  |  |
|------------------|--|
| October 2, 1996  | - Acute Myocardial Infarction                |
| November 6, 1996 | - Clinical Electrocardiography               |
| December 4, 1996 | - Reperfusion in Acute Myocardial Infarction |

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The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

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### SEPTEMBER 1996

SEPTEMBER 4th

**Hypertension Management in Renal Insufficiency**  
*Michael A. Moore, M.D.*

Clinical Assistant Professor of Medicine  
Bowman Gray School of Medicine, Director,  
Danville Urologic Clinic, Danville, VA

SEPTEMBER 11th

**Diagnosis and Treatment of Cardiac Arrhythmias  
for the Practicing Physician**

*Michael Cain, M.D.*

Lewin Professor of Medicine  
Director, Cardiovascular Diseases, Washington  
University School of Medicine, St. Louis, MO

*Steven P. Kutalek, M.D.*

Associate Professor of Medicine  
Director, Cardiac Electrophysiology, Allegheny  
University Hospitals, Center City

SEPTEMBER 18th

**The Molecular Basis of the Acute Coronary  
Syndrome—Mechanisms of Plaque Rupture in  
Acute Coronary Events**

*Peter Libby, M.D.*

Associate Professor of Medicine  
Harvard Medical School, Director, Vascular  
Medicine and Atherosclerosis Unit, Brigham and  
Women's Hospital, Boston, MA

SEPTEMBER 25th

**Advances in Therapy of HIV: Mechanisms of Action  
of Newest Antiretroviral Therapy**

*Paul Volberding, M.D.*

Professor of Medicine  
University of California at San Francisco, Chief,  
AIDS Activity Service, San Francisco General  
Hospital, San Francisco, CA

### OCTOBER 1996

OCTOBER 2nd (8:30 to 12 noon)

**Mechanisms and Advances in Treatment of  
Congestive Heart Failure**

*Eugene Braunwald, M.D.*

Hershey Professor of the Theory and Practice of  
Medicine, Harvard Medical School, Chairman,  
Department of Medicine, Brigham and Women's  
Hospital, Boston, MA

OCTOBER 9th

**Advances in Pulmonary Medicine**

*David M. Center, M.D.*

Division of Pulmonary Medicine, Boston University  
Medical Center, Boston, MA

OCTOBER 16th

**Advances in Cardiovascular, Renal and  
Cerebrovascular Medicine with Adenosine**

*Ami Iskandrian, M.D.*

Professor of Medicine  
Director, Nuclear Cardiology, Division of  
Cardiovascular Diseases, Allegheny University  
Hospitals, Center City

*Luiz Belardinelli, M.D.*

Professor of Medicine and Pharmacology  
Department of Medicine, University of Florida  
School of Medicine, Gainesville, FL

*Christopher Grange, M.D.*

Associate Professor of Medicine  
Duke University School of Medicine, Durham, NC

*Robert Mentzer, Jr., M.D.*

Professor and Chairman  
Cardiothoracic Surgery, Director, Cardiopulmonary  
Transplantation, University of Wisconsin Hospital  
and Clinic, Madison, WI

### OCTOBER 1996

OCTOBER 23rd

**Disorders of the TSH Receptor**

*Martin I. Surks, M.D.*

Professor of Medicine and Pathology  
Albert Einstein School of Medicine, Head, Division  
of Endocrinology and Metabolism, Montefiore  
Medical Center, Bronx, NY

OCTOBER 30th

**Advances in Allergy/Immunology for the Practicing  
Physician**

*David M. Lang, M.D.*

Assistant Professor of Medicine  
Chief, Division of Allergy/Immunology, Allegheny  
University Hospitals, Center City

### NOVEMBER 1996

NOVEMBER 6th

**The Changing Face of Community-Acquired  
Pneumonias: The Impact of Pneumococcal  
Resistance**

*Daniel N. Musher, M.D.*

Professor of Medicine, Microbiology and  
Immunology  
Baylor College of Medicine, Chief, Infectious  
Diseases, VA Medical Center, Houston, TX

NOVEMBER 13th

**Advances in the Treatment of Asthma**

*David M. Lang, M.D.*

Assistant Professor of Medicine  
Chief, Division of Allergy/Immunology, Allegheny  
University Hospitals, Center City

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

SEPTEMBER 11, 1996

**Diagnosis and Treatment of Cardiac  
Arrhythmias in Office Practice**

Course Director: Steven P. Kutalek, M.D.

Visiting Professor: Michael Cain, M.D.  
Washington University School of Medicine

OCTOBER 9, 1996

**Advances in Pulmonary Medicine  
Treatment of COPD**

Course Director: Edward S. Schulman, M.D.

Visiting Professor: David M. Center, M.D.  
Boston University Medical Center

OCTOBER 16, 1996

**Advances in Cardiovascular, Renal and  
Cerebrovascular Medicine with Adenosine**

Course Director: Ami Iskandrian, M.D.

Visiting Professors: Luiz Belardinelli, M.D.,  
University of Florida School of Medicine  
Christopher Grange, M.D., Duke University  
School of Medicine

Robert Mentzer, Jr., M.D., University of  
Wisconsin Hospital and Clinic

OCTOBER 30, 1996

**Advances in Allergy/Immunology  
for the Practicing Physician**

Course Director: David M. Lang, M.D.

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service,  
Director of Continuing Medical Education for the Department of Medicine

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continued from page 72

## Executives to lead PHPNJ

The Physician Healthcare Plan of New Jersey (PHPNJ) has appointed Ernest Monfiletto and Carlos Beharie, MD, to the senior management team. Mr. Monfiletto will serve as the chief executive officer and Dr. Beharie will serve as the chief medical officer. "Mr. Monfiletto and Dr. Beharie give PHPNJ the strong, seasoned management team that will lead our company through our first year of licensed operation and to a successful future," said a statement from PHPNJ.



Ernest Monfiletto



Carlos Beharie, MD

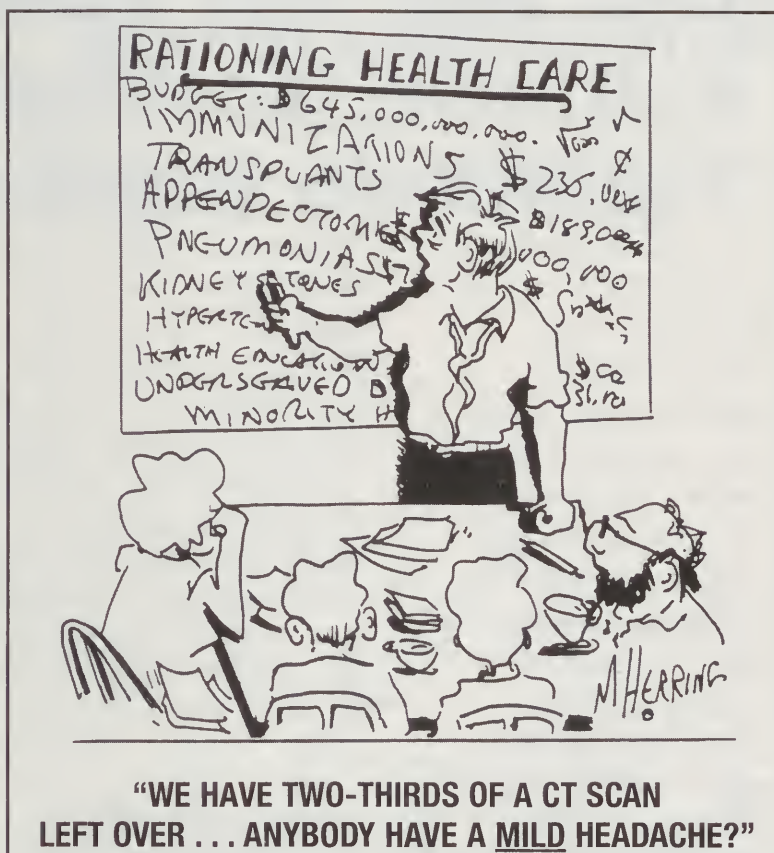
## MSNJ physician at Olympics

Vincent K. McNerney, MD, was in Atlanta as a team physician for the U.S. Team Handball team; he also served at the 1984 Olympics in Los Angeles, the 1992



Dr. McNerney

Barcelona Olympic Games, and the 1986 Moscow and 1994 St. Petersburg, Russia Goodwill Games. Dr. McNerney is a clinical orthopaedist and director of sports medicine at St. Joseph's Medical Center in Paterson. Dr. McNerney is chair of the MSNJ Committee on Medical Aspects of Sports and is the president of The Academy of Medicine of New Jersey.



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine.

## Names in the news

Rose P. Prystowsky, MD, a member of MSNJ, is the recipient of the 1996 Golden Merit Award by the New Jersey Psychiatric Association. Frank Sparandero, MD, has assumed the role of corporate vice-president of medical affairs for the Franciscan Health System of New Jersey. Dr. Sparandero is the president of Somerset County Medical Society and serves as the vice-chair of the MSNJ Committee on Medical Education. Also serving on the MSNJ Committee on Medical Education is Frederic Primich, MD, president of the Middlesex County Medical Society.

## NJ doctors win AMA positions

Palma E. Formica, MD, was re-elected to her third three-year term on the AMA Board of Trustees. A past-president of MSNJ and The Academy of Medicine of New Jersey, Dr. Formica's achievements over the years include the New Jersey Hospital Association's Special Recognition Award, the Virginia Apgar Award, presented by the March of Dimes, and the Benemerenti Medal from the pope. Robert J. Weierman, MD, was elected chair of the Organized Medical Staff Section. Dr. Weierman serves as an AMA delegate; he also is a member of the MSNJ Council on Medical Services and a delegate to the MSNJ House of Delegates.



Dr. Formica



## MSNJ OFFERS NEW HEALTH AND DENTAL INSURANCE PROGRAM

MSNJ announced a new comprehensive health and dental insurance program for members. Blue Cross Blue Shield of New Jersey (BCBSNJ) has been selected as MSNJ's insurance carrier based on the strength of the company, the relationship it has developed with providers and hospitals throughout New Jersey, as well as its competitive rates. The Olympic Agency, a full-service insurance broker, will assist members with enrollment and selection of appropriate insurance coverage.

Whether members are seeking coverage for themselves, their family, or their employees, they can select from traditional fee-for-service indemnity insurance products or from a variety of managed care plans including point of service, preferred provider organization, and HMO coverage. Also, the program offers attractive benefit enhancements to MSNJ members such as a 95 percent prescription benefit program for members of small employer groups and a discounted dental program for those who select an individual insurance product.

For more information, call BCBSNJ at 1/800/682-7694 or the Olympic Agency at 201/669-3150.

### Falla named miracle worker

Millburn resident Anita Falla, MD, received the 1996 Miracle Maker Award from the Children's Miracle Network. The award recognizes physicians who make miracles happen every day through dedicated service and care to their patients, their hospital, and the community. Dr. Falla is director of pediatric surgery at United—the Children's Hospital of New Jersey. A member of the AMA and of the Essex Coun-



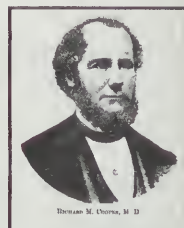
Anita Falla, MD

ty Medical Society. Dr. Falla serves MSNJ as a delegate to the House of Delegates and as chair of the Judicial Council; previously she was a member of the Committee on Women in Medicine.

### History in the making

To celebrate the sesquicentennial anniversary of the Camden County Medical Society, a historical gala will be held on October 18, 1996, at the Tavistock Country Club in Haddonfield. All attendees of this black tie or period dress affair will receive a commemorative book written for

the occasion by Henry H. Sherk, MD. For tickets to this celebration, call the Camden County Medical Society at 609/772-0800.



Richard M. Cooper, MD, was one of the founding fathers and first secretary of the Camden County Medical Society and a past-president of MSNJ.

### New medical staff president

Harold I. Jawetz, MD, of Passaic, has been named president of the medical staff at Passaic Beth Israel Hospital, having previously served as the medical staff's vice-president, secretary, and treasurer. Since 1989, Dr. Jawetz was the medical director of respiratory therapy at Passaic Beth

Israel Hospital and is a past-president of the medical staff at Daughters of Miriam, in Clifton. He

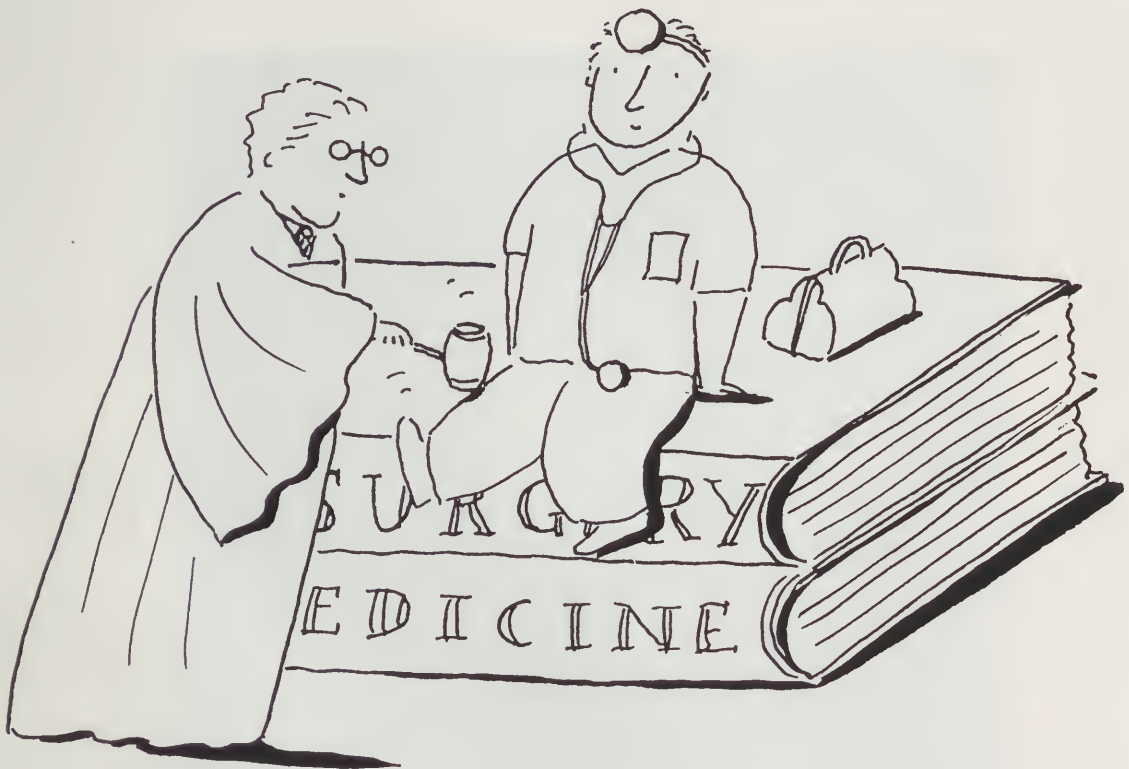
is a member of the AMA, MSNJ, and the Passaic County Medical Society.



Harold I. Jawetz, MD

*continued on page 71*

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*Health Care in the Garden State*

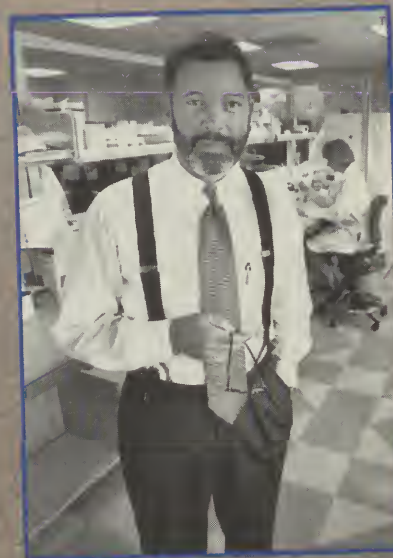
*September 1996*

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## newsWATCH

Health care could be improved substantially under new standards proposed as HEDIS 3.0. On July 16, the National Committee for Quality Assurance (NCQA) released the long-awaited list of measures for evaluating HMOs.

Seventy-five "reporting" and 30 trial or "testing" standards were announced (Table). According to NCQA, all were "specifically designed to help purchasers and consumers make comparisons." If adopted following a comment period that expires this month, the standards will be implemented next year, taking their place alongside NCQA's accreditation standards as the most widely used markers of HMO excellence.

Although applicable only to HMOs, the HEDIS (Health Plan Employer Data and Information Set) standards are potentially attainable by other managed care organizations and independent health care providers. Accordingly, the standards form an important compendium of patient and purchaser expectations for clinicians.

HEDIS 3.0 was developed by a 24-member **Committee on Performance Measurement**, including one ostensible New Jerseyan, former federal official and current **Prudential** chief medical officer **William L. Roper, MD, MPH**.

The predecessor list, HEDIS 2.0, contained only nine quality of care-related standards. Retained are standards for childhood immunization, mammography, Pap smears, avoidance of low birth weights, prenatal care, retinal examinations for diabetics, and ambulatory followup to hospitalizations for major affective disorders. Dropped or revised were HEDIS 2.0 standards for cholesterol screening and avoidance of hospital admissions for asthma.

Unhappily, NCQA's typically inflated rhetoric may obscure the accomplishment of producing an impressive array of measures with clear relevance to most patients. To illustrate, NCQA blithely asserts that HEDIS 3.0 is outcomes-oriented and focused on results instead of processes of care. In fact, all but 1 of the 16 "effectiveness of care" reporting standards measure screenings and other processes, not patient outcomes or health status. (Bear in mind, though, the enormous difficulties of generating true outcome standards that are applicable to most populations, easily and reliably measured, validly indicative of quality of care, yet interesting to consumers.)

Illustrative of the breadth of HEDIS 3.0 are the following measures: **health of seniors**, an outcome standard determined by a survey of enrollees asking whether their ability to function has improved over time; **telephone access**, noting the HMO or health plan's own standard for telephone waiting times; **availability of primary care**, judged by how many primary care providers are accepting new patients; **annual health care survey**, a patient satisfaction standard that NCQA intends to implement through a uniform questionnaire supplemented with modules for Medicare beneficiaries and Medicaid recipients; **provider compensation**, mechanisms for paying physicians that may create economic incentives for either overutilization or underutilization; **quality improvement**, a standard that offers HMOs an opportunity to demonstrate innovative and highly successful programs; and **recredentialing**, the presence of a system for verifying providers' credentials.

**The Department of Health and Senior Services (DHSS) has announced a collaborative effort**



with the Centers for Disease Control to measure hospital lengths of stay (LOS) for vaginal deliveries over a seven-week period this summer. Coordinating the project is DHSS's **Virginia Dato, MD**.

Obstetric LOS is a bone of contention among diverse groups: HMOs and other third-party payers chafing under new state legislation prohibiting discharges before 48 hours; hospitals contending that HMOs are meeting the letter of the law but not the spirit by paying hospitals on a reduced per-case fee basis; and patients and physicians who support the law and are less interested in payment ramifications.

**Atlantic, Bergen, Camden, Essex, Morris, Ocean, Somerset, and Union counties** have all been selected as demonstration sites for DHSS's new NJ-EASE (Easy Access, Single Entry) program intended to streamline access to state services for the elderly.

Selection of 8 of the state's 21 counties as pilot sites was ambitious, but only 4 of the counties—Atlantic, Morris, Ocean, and Union—are slated for phase one action this year. Assistant Commissioner **Ruth Reader** is one of the DHSS officials involved.

And, **Newark** has been chosen—randomly—as 1 of 12 cities to be monitored with "high intensity" through the widely touted Community Tracking Study. The ongoing investigation will be conducted by the new Center for Studying Health System Change in Washington, DC, led by **Paul B. Ginsburg**. In the study, changes in the health system and in outcomes of care will be explored in two-year cycles.

**Health Volunteers Overseas (202/296-0928)** is looking for a few good health professionals.

Those selected will be assigned to train practitioners in Africa, Asia, and Latin America.

Last year's crop of volunteers from the Garden State included: **Roger Blauvelt; Donald Elliott, CRNA; Salvatore LaPilusa, MD; Jeff Levin, DMD; Arganey Lucas, MD; Margaret Lucas, CRNA; Marie O'Toole, EdD, RN; Diane Rovatsos, RN; and Thomas Stackhouse, MD.**

**Why have concerns been raised about a physician surplus? According to the AMA's new 1996 medical licensure report, the number of new medical licenses increased 39 percent, to nearly 50,000, between 1974 and 1994. The 1994 figure includes 1,400 MDs and DOs licensed by the New Jersey state Board of Medical Examiners.**

Nearly one-half of New Jersey's initial licenses are awarded to international, or foreign-trained, medical graduates (IMGs). Of 475 new state licenses issued in 1994, IMGs accounted for 224. Approximately two-fifths of new licenses are considered initial, for purposes of these statistics.

On the opening day of the Republican National Convention, co-chair Christie Whitman introduced AIDS activist Mary Fisher, whose natural talent for establishing presence and credibility may rival Mrs. Whitman's. In turn, Mrs. Fisher presented 12-year-old Hydia Broadbent, who recited her own poem, including the line: "I am the future. I have AIDS." Afterwards, the Governor warmly hugged both presenters. Why not now seek gubernatorial support for reasonable and compassionate HIV measures?

**Neil E. Weisfeld**



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## Table. Reporting and Testing Standards.

### 1996 HEDIS 3.0 Reporting Set Measures

#### Domain: Effectiveness of Care

- ✱ Childhood Immunization Status
- ✱ Adolescent Immunization Status
- ✱ Flu Shots for High-Risk Adults
- ✱ Flu Shots for Older Adults
- ✱ Breast Cancer Screening
- ✱ Cervical Cancer Screening
- ✱ Prenatal Care in the First Trimester
- ✱ Low Birth Weight Babies
- ✱ Checkups after Delivery
- ✱ Treating Children's Ear Infections
- ✱ Beta Blocker Treatment after a Heart Attack
- ✱ Use of Appropriate Medications for People with Asthma
- ✱ Eye Exams for People with Diabetes
- ✱ Followup after Hospitalization for Mental Illness
- ✱ Advising Smokers To Quit
- ✱ Health of Seniors

#### Domain: Access/Availability of Care

- ✱ Appointment Access
- ✱ Telephone Access
- ✱ Adults Access to Preventive/Ambulatory Health Services
- ✱ Children's Access to Primary Care Providers
- ✱ Availability of Primary Care Providers
- ✱ Availability of Mental Health/Chemical Dependency Providers
- ✱ Availability of Obstetrical and Prenatal Care Providers
- ✱ Initiation of Prenatal Care
- ✱ Low Birth Weight Deliveries at Facilities for High-Risk Deliveries and Neonates
- ✱ Annual Dental Visit
- ✱ Availability of Dentists
- ✱ Availability of Language Interpretation Services

#### Domain: Satisfaction with the Experience of Care

- ✱ The Annual Member Health Care Survey
- ✱ Survey Descriptive Information

#### Domain: Health Plan Stability

- ✱ Disenrollment
- ✱ Physician Turnover
- ✱ Years in Business/Total Membership
- ✱ Performance Indicators
- ✱ Narrative Information on Rate Trends, Financial Stability, and Insolvency Protection

#### Domain: Use of Services

- ✱ Well-Child Visits in the First 15 Months of Life
- ✱ Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- ✱ Adolescent Well Care Visit
- ✱ Frequency of Selected Procedures
- ✱ Inpatient Utilization—General Hospital/Acute Care
- ✱ Ambulatory Care
- ✱ Inpatient Utilization — Non-Acute Care
- ✱ Discharge and Average Length of Stay for Females in Maternity Care
- ✱ Cesarean Section and Vaginal Birth After Cesarean Rate (VBAC-Rate)
- ✱ Births and Average Length of Stay, Newborns
- ✱ Mental Health Utilization—Inpatient Discharges and Average Length of Stay
- ✱ Mental Health Utilization—Percentage of Members Receiving Inpatient, Day/Night, and Ambulatory Services
- ✱ Readmission for Specified Mental Health Disorders
- ✱ Chemical Dependency Utilization—Inpatient Discharges and Average Length of Stay
- ✱ Chemical Dependency Utilization—Percentage of Members Receiving Inpatient, Day/Night Care, and Ambulatory Services
- ✱ Readmission for Chemical Dependency
- ✱ Outpatient Drug Utilization
- ✱ Frequency of Ongoing Prenatal Care

#### Domain: Cost of Care

- ✱ High-Occurrence/High-Cost DRGs
- ✱ Rate Trends



**Domain: Informed Health Care Choices**

- ✧ Language Translation Services
- ✧ New Member Orientation/Education

**Domain: Health Plan Descriptive Information**

- ✧ Board Certification/Residency Completion
- ✧ Arrangements with Public Health, Educational, and Social Service Entities
- ✧ Provider Compensation
- ✧ Total Enrollment
- ✧ Physicians Under Capitation
- ✧ Enrollment by Payer (Member Years/Months)
- ✧ Case Management
- ✧ Unduplicated Count of Medicaid Members
- ✧ Utilization Management
- ✧ Cultural Diversity of Medicaid Membership
- ✧ Risk Management
- ✧ Weeks of Pregnancy at Time of Enrollment
- ✧ Quality Assessment/Improvement
- ✧ Pediatric Mental Health Network
- ✧ Recredentialing
- ✧ Chemical Dependency Services
- ✧ Preventive Care and Health Promotion
- ✧ Family Planning

**1996 HEDIS 3.0 Testing Set Measures**

**Domain: Effectiveness of Care**

- ✧ Chlamydia Screening
- ✧ Cholesterol Management of Patients Hospitalized for Coronary Artery Disease
- ✧ Monitoring Diabetes Patients
- ✧ Aspirin Treatment after a Heart Attack
- ✧ Substance Counseling for Adolescents
- ✧ Controlling High Blood Pressure
- ✧ Number of People in the Plan Who Smoke
- ✧ Continuity of Care — Substance Abuse
- ✧ Smokers Who Quit
- ✧ Availability of Medication Management — Schizophrenia
- ✧ Colorectal Cancer Screening
- ✧ Patient-Reported Behavioral Health Measure
- ✧ Followup after Abnormal Pap Smear
- ✧ Family Visit for Children 12 Years of Age or Younger
- ✧ Followup after Abnormal Mammogram
- ✧ Treatment Failure — Substance Abuse
- ✧ Stage at which Breast Cancer Was Detected
- ✧ Chemical Dependency Screening
- ✧ Prevention of Stroke in People with Atrial Fibrillation
- ✧ Diagnosis Supporting the Use of Psychotherapeutic Agents
- ✧ Outpatient Care of Patients Hospitalized for Congestive Heart Failure
- ✧ Rate of Continuation Treatment of Depression
- ✧ Functional Assessment of Breast Cancer Therapy
- ✧ HIV Patient Management

**Domain: Access/Availability of Care**

- ✧ Problems with Obtaining Care

**Domain: Satisfaction with the Experience of Care**

- ✧ Disenrollment Survey
- ✧ Satisfaction with Breast Cancer Treatment

**Domain: Cost of Care**

- ✧ Health Plan Costs

**Domain: Informed Health Care Choices**

- ✧ Counseling Women about Hormone Replacement Therapy

**Domain: Use of Services**

- ✧ Use of Behavioral Health Services

**Source:** HEDIS 3.0 Draft for Public Comment, July 1996, National Committee for Quality Assurance.

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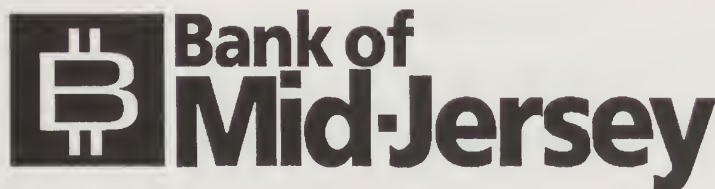
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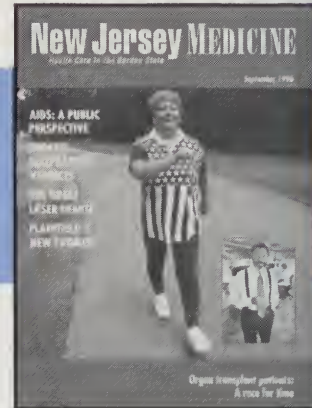
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Thanks to one of New Jersey's transplant programs, Union County resident Ann O'Hanlon is a successful recipient of a heart transplant and participated in the Transplant Olympics as a marathon walker. She also is an active volunteer at The Sharing Network, under the direction of Executive Director Dr. Mark Smith (inset).



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# New Jersey MEDICINE

## Asthma care

Drs. Bielory and Goldberg present an interesting and impassioned view of the care of individuals with asthma (NJ MED March 1996). There is perhaps a little more to the story. As Drs. Bielory and Goldberg point out, studies show improved outcomes of asthma with the use of nedocromil sodium.<sup>1,2</sup> This drug can be given by generalists as well as specialists. Improved outcomes should be associated with the treatment not the person prescribing the treatment.

Some of the studies cited by the authors deal with the most severe cases of asthma, those requiring hospitalization and emergency medical care.<sup>3-6</sup> To expand from this subgroup of patients to all patients with asthma is a generalization that is not justified.

Drs. Bielory and Goldberg also must remember that not every child or adult lives in the same community as an allergist. The 25 percent of the U.S. population that lives in rural areas may not have easy access to an allergist.

To improve the care of children and adults with asthma, we can regiment who provides care or we can decide what is the best program of care and help physicians provide that

level of care. This is exactly what the National Heart, Lung and Blood Institute is attempting to do with the development and update of the National Asthma Treatment and Education Guidelines.

I hope allergists will accept the responsibility to educate themselves and their colleagues; and primary care physicians will be enthusiastic students.

*Barbara P. Yawn, MD, MSc,  
Director of Research, Olmsted  
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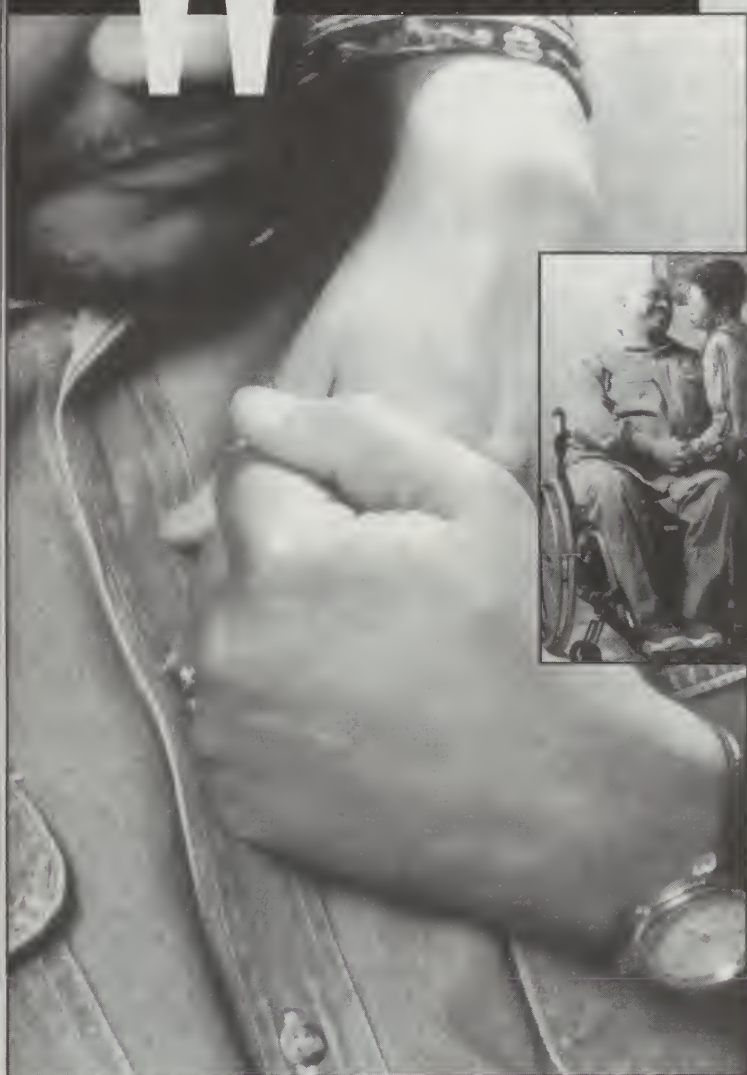
## Camden County Medical Society's sesquicentennial

This year marks the sesquicentennial anniversary of the Camden County Medical Society (CCMS). The story of the origin of CCMS is linked to the story of the creation of Gloucester County and the requirements made by the New Jersey Legislature and the Medical Society of New Jersey (MSNJ).

Very few physicians were available to the citizens of Camden County in 1844, and no organization had been established or created to provide medical care to them. Procedures were needed to

*continued on page 12*

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continued from page 10

ensure the public health, and some type of organizational structure also was necessary to certify and license doctors. Fortunately, MSNJ had established mechanisms to cover these exigencies, and local physicians in Camden County were able to adapt them to local needs.

In 1846, medical care in Camden County was essentially unregulated. There had been lax enforcement of the laws governing licensure, and apparently few qualified physicians were on hand. The city of Camden was the largest in the southern part of the state, and the countryside remained largely forests and scattered farms. Towns were connected by a few sandy roads, and transportation and communication were difficult. James K. Polk was president of the United States, and the country was engaged in an unpopular war with Mexico.

A few serious men came forward for the purpose of developing a system whereby the progress of science and application of rational principles to illness, injury, and disease could flourish. They were backed by laws that made it possible to define the standards for entry into the profession and to provide a mechanism whereby people who met the standards could be certified as legal practitioners. In 1846, the standards for entry into medicine were either the

successful completion of an apprenticeship with a licensed physician, or the receiving of a diploma from one of the four accredited medical schools: the University of Pennsylvania, Jefferson Medical College, the University of Maryland, and the College of Physicians and Surgeons in New York. Once a candidate had met these standards, he could only be certified and licensed to practice by passing the examination of a committee of censors appointed by the county medical society. The Legislature acted to discourage the illegal practice of medicine by imposing fines and penalties.

Only licensed physicians who were members of MSNJ could organize a county medical society. Drs. James S. Risley of Berlin and Charles D. Hendry of Haddonfield met these standards and presented an application for the development of a county society in Camden County at the 80th Annual Meeting of MSNJ, in New Brunswick, on May 2, 1846; a commission to orga-

nize the county society was appointed. On August 14, 1846, Drs. Risley and Hendry were joined by Drs. Jacob R. Thornton, Richard Matlack Cooper, and Othniel H. Taylor. Dr. Isaac S. Mulford had been invited, but could not attend because he was ill. This group established a constitution for the Camden County Medical Society (CCMS) and passed bylaws. They were approved by MSNJ in 1847 at its May meeting, and a county society meeting of an accredited Camden County Medical Society took place on June 15, 1847.

The above information was excerpted from *Colleagues and Competitors: A Sesquicentennial History of the Camden County Medical Society 1846-1996*, by Henry H. Sherk, MD, CCMS historian.

A dinner celebrating this anniversary will be held on October 18, 1996, at Tavistock Country Club in Haddonfield.

Joseph H. Reichman, MD  
President, CCMS

### Kick-Off Picnic

A benefit for the newly established NJ Breast Cancer Research Fund will be held on September 29, 1996, at Drumthwacket, the governor's residence in Princeton. The Honorable Christine Todd Whitman and Mr. John Whitman are honorary chairs. The New Jersey Breast Cancer Coalition will host the event to kick off the Fund's availability on the New Jersey income tax form as a voluntary check-off box. For picnic tickets call, 908/247-0071.

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## ER head named

Kennedy Memorial Hospital-University Medical Center/Washington Township announced that Alison J. McDonald, MD, is the new medical director of the Emergency Department. Dr. McDonald will be responsible for overseeing medical care and quality outcomes as well as coordination of medical coverage for the emergency room. Dr. McDonald is board certified in emergency medicine and internal medicine and is a fellow of the American College of Emergency Physicians.



*Dr. McDonald,  
Medical Director*

## Top paramedics

James Rogers and Nelson Seijas of the Jersey City Medical Center Emergency Medical Services System received the 1996 Paramedic Team Excellence Award presented by the New Jersey Association of Mobile Intensive Care Administrators. Paramedics Rogers and Seijas were selected by their peers for excellence in working effectively as a member of the paramedic team, being well rounded in their professional continuing education, and consistency in excellence of performance.



*James Rogers and  
Nelson Seijas*

## New faces at AMNJ

The Academy of Medicine of New Jersey (AMNJ) announced its officers for 1996-1997. They are: **Vincent K. McNerney, MD**, president; **Sofia H. Anthony, MD**, president-elect; **Robert R. Rickert, MD**, vice-president; **John Sensakovic, MD, PhD**, second vice-president; **Connie Uy, MD**, secretary; and **Bernard A. Rineberg, MD**, treasurer. New members of the Board of Trustees for the 1996-1999 term are: **Thomas Butler, DMD**; **Anthony Garro, PhD**; **Andrew Kunish, MD**; **Roger Moore, MD**; and **Sigmund Sattenspiel, MD**. Drs. Kunish, McNerney, Moore, Rickert, Rineberg, and Sattenspiel are members of MSNJ.

## Coia named chair at regional cancer center

**Lawrence Coia, MD**, has been named chair of the Department of Radiation Oncology, Community-Kimball Health Care System. Dr. Coia most recently was affiliated with Fox Chase Cancer Center. Dr. Coia is a member of the

American College of Radiology, the American Society of Clinical Oncology; the American Society of Therapeutic Radiology and Oncology; the Radiation Research Society; and the American Radium Society.



*Dr. Coia*

## Weitz as executive director

**Ronald W. Weitz**, has been named the executive director at Newark Beth Israel Medical Center. Formerly, Mr. Weitz

was president and chief executive officer at The Hospital Center at Orange.



*Ronald W. Weitz*

## Nurse practitioners' new role

Raritan Bay Medical Center in Perth Amboy announces its first nurse practitioner, **Noel Dougherty Rosner, RN, MSN**. Ms. Rosner is board certified by the American

Academy of Nurse Practitioners. The nurse practitioner's role in today's changing health industry has expanded.



*Noel Dougherty  
Rosner, RN, MSN*

*continued on page 16*



# 1996 *Person of the Year*

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Nominator's signature \_\_\_\_\_

Nominator's name (please print) \_\_\_\_\_

Telephone and FAX \_\_\_\_\_

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continued from page 14

## A leader in burn care

**The Burn Center** at Saint Barnabas Medical Center, in Livingston, has been recognized as one of the best burn care providers in the country by the American Burn Association and the American College of Surgeons. The Center is supported by the Saint Barnabas Burn Foundation, which provides financial assistance to victims and their families, educational programs, and support for clinical research projects. Sari Kaplon, RN, is the administrative director of the Center and David A. Wagner serves as the executive director of the Saint Barnabas Burn Foundation.



Sari Kaplon,  
administrative director



David A. Wagner,  
executive director

## HMO hotline

**The New Jersey State Department of Insurance and Banking has a hotline telephone number for handling complaints on HMOs. To discuss your concern by telephone with a staff member, call 609/292-5316.**

## 21-day notification law

The 21-day notification law will become effective for accidents occurring after July 8, 1996. The formal proposal of rules to implement this law was published in the *New Jersey Register*. Interested persons have 30 days to submit comments on the proposals.

Prior to adoption of this rule, medical providers can satisfy the notification requirements of

the law by one of the following: 1) submitting a bill or invoice for payment to the automobile insurance carrier within 21 days following the date treatment commences. Submission may be made by certified mail, regular mail (date of postmark will be deemed date of notification), or via fax transmission; or 2) providing the following basic information to the automobile insurance carrier within 21 days following the date

treatment commences. Submission may be made by certified mail, regular mail (date of postmark will be deemed date of notification), or via fax transmission. You need to submit: name, address, and telephone number of treating medical provider; name and address of patient and name and address of insured; insurer name and address; date of accident/injury; and date of first treatment.

## New MIIX Healthcare Group



David Knowlton

Knowlton & Associates and Costante Associates, Inc. merged with the Medical Inter-Insurance Exchange (MIIX) to form the new **MIIX Healthcare Group**. David I. Knowlton will head the group. Upon appointment, Mr. Knowlton

commented, "This merger is exciting and an opportunity to provide a broad new range of service and insight to our clients." MIIX Healthcare Group can be reached at 609/896-2404.

## Hearn named VP



Ruby P. Hearn, PhD

**Ruby P. Hearn, PhD**, has advanced to senior vice-president at The Robert Wood Johnson Foundation, in Princeton. Dr. Hearn joined The Foundation in 1976. Dr. Hearn is a member of the Institute of Medicine's governing council, the Council on Foundation's Board of Directors, the Food and Drug Administration's Science Board, and the National Academy of Sciences Committee on Science, Engineering, and Public Policy.

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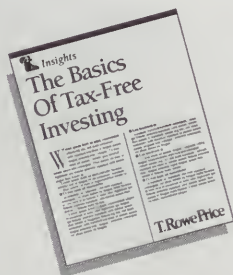
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### The times they are a-changin'

The House of Delegates (HOD) of the Medical Society of New Jersey (MSNJ) adopted Resolution #6 at its Annual Meeting this May. The resolution was sent statewide with an attached preamble, "The MSNJ HOD believes that HIV infection has been overly politicized and not dealt with as a major medical crisis. The following position has been adopted, and is being sent to you for your information and hopefully your action:

All New Jersey hospitals should adhere to the Centers for Disease Control guidelines that state, 'Hospitals with an HIV prevalence rate of at least 1 percent or an AIDS diagnosis rate equal to or greater than 1 per 1,000 discharges should adopt a policy of offering HIV counseling and testing routinely to patients ages 15 to 54 years of age.'

Your cooperation in this critical public health matter is appreciated."

On June 27, 1996, the HOD of the American Medical Association (AMA), which considered the MSNJ recommendation, approved a resolution calling for mandatory HIV testing of all pregnant women and newborns. The tally was 185 to 181, which, unfortunately, reminds some of the greeting card that says, "Your fellow workers wish you a speedy recovery, by a vote of 9 to 8." The AMA action reversed its former policy of voluntary testing and received immediate criticism from representatives of the American College of

Obstetricians and Gynecologists, among others, who felt that the threat of mandatory testing would keep patients from their physicians.

The AMA change in policy parallels those made by MSNJ in recent years, as reported in the 1996 *Policy Compendium*. In 1990, the MSNJ HOD asked

that we treat HIV infection as a reportable communicable disease; our Board of Trustees amplified this by saying HIV testing should be done when indicated, to include all those in high-risk groups, but that the results should not be used to discriminate, and the testing should be only for diagnostic purposes. MSNJ liberalized its position by HOD action in 1991, by supporting "universal confidential HIV testing on all hospitalized patients and health care personnel."

In 1992, MSNJ opposed mandatory premarital HIV testing and in 1993, MSNJ opposed "mandatory written consent for HIV/AIDS testing" and endorsed informed non-mandatory consent, counseling, and increased education of physicians and the laity. In 1994, MSNJ again supported counseling and the voluntary testing of all pregnant women. Parenthetically, it should be noted that President Clinton signed an



Howard D. Slobodien, MD

*"Social responsibility is a cherished attribute of the medical profession. It is time for physicians to reclaim it and support it."*



Society is...a partnership not only between those who are living, but between those who are living, those who are dead, and those who are to be born.

Edmund Burke, *Reflections on the Revolution in France*, 1790.

We live in society; there is therefore nothing truly good for us except that which does good to society.

Voltaire, "Virtue," *Philosophical Dictionary*, 1764.

authorization bill in May 1996 requiring mandatory testing of newborns if there was too little voluntary testing of pregnant women. This action was predicated on the evidence that treatment given to HIV-positive mothers before and during birth could cut the incidence of HIV-infected newborns by two-thirds.

Then came the XI International Conference on AIDS, held in Vancouver from July 7 through July 12, 1996. And our view of the world of HIV/AIDS changed significantly.

Lawrence Altman, reporting on the opening day in *The New York Times*, noted a "new spirit of cautious optimism" and felt an "exuberance" replacing the pessimism of previous conferences. Reports of the increased effectiveness of combinations of drugs and of the value of adding protease inhibitors gave rise to optimism, although the use of the term "cure" was considered premature and continued investigation was deemed essential. There was much discussion about the need for vaccines, especially in developing countries, and of the need to offer some type of shield for women whose partners refused to use protection.

Major strides have been made, both in treatment and in prevention. As Altman headlined on July 14, "AIDS may become a chronic but treatable illness." David W. Dunlap, in the same newspaper, trumpeted, "After AIDS conference, talk of life, not death." Many of those afflicted now plan to reclaim their previous productive lives, lives that had been given up for lost, while they mourn the other 300,000 who had died before they had a chance to receive what seems to be the beginning of the beginning of the control of AIDS.

We must temper the good news by accepting some negative realities. There are side effects; these are powerful drugs. There is continued worry about mutations, both natural ones and those produced by the medications. The costs of treatment are huge, and yearly estimates range from \$12,000 to \$85,000; pharmaceutical companies already are being accused of price-gouging. Third-world countries may fail to reap the benefits because of economic factors. Fortunately, government at various levels will pay for these newer drugs in many instances, and many managed care companies will do likewise. Unfortunately, some governmental bodies and some managed care companies do not, and the middle-income patient may be left uncovered. These loopholes must be closed. And our educational efforts must be increased; Jane Miller's article in this issue points out the public's woeful lack of understanding.

Most importantly, we must finally treat HIV/AIDS as a public health problem. We have reached the point where treatment can help, perhaps even arrest, the disease. Early intervention is more effective and can prevent infection. The time has come for mandatory testing of certain populations: the pregnant woman, the newborn, the blood donor, most hospitalized patients, and others, the specific groups to be determined by experts in the field. Confidentiality should be cherished and guarded, but there are times when the protection of the citizenry takes precedence. Social responsibility has long been a cherished attribute of the medical profession. It is time for us to reclaim it and time for society to support such efforts.



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## INTERVIEW WITH JULANE MILLER

**Julane Miller is president/CEO, Plainfield Health Center. She also is a member of the NJM Review Board.**

**Q.** What services does the Plainfield Health Center provide?

**A.** The Plainfield Health Center is a federally qualified health center that is funded in part through the Public Health Service. We provide a comprehensive range of primary care services including ob/gyn, family planning, pediatrics, dental, minor surgery, adult medicine, and ophthalmology, which we recently added. We also offer support services such as social work and outreach, translators, HIV services, and case management.

**Q.** In terms of the population you serve, what are the biggest challenges from a health care perspective?

**A.** One of our biggest challenges is promoting health maintenance for chronic illnesses, so that people do not rely upon episodic care for hypertension or asthma, for example. Education always is a challenge. Another challenge is the high incidence of HIV infection in our area, which itself is secondary to substance abuse. We don't offer substance abuse counseling, but we screen for it, and will refer patients. And finally, perinatal care is another major area of concern from the perspective of getting people into care early in their pregnancies.

**Q.** There have been some proposed changes in Medicaid reimbursement to federally qualified health centers. How would they affect you?

**A.** In the past we have been reimbursed by Medicaid on a fee-for-service, cost-based



*Julane Miller*

system. Entering the managed care arena, which will become mandatory under Medicaid, reimbursement will switch to a capitation system. This will put pressure on us to provide the same services with less revenue. We will have to find ways to be more cost effective or reduce the scope of services.

Our services are driven basically by identified community needs. We offer more support services than you might find in a private physician's office, but those services are costly and generally are not reimbursed.



So at this point we have to look again at what we are offering, what realistically will be paid, and how we still can meet the needs of the community without carrying all of that cost. It may mean using mid-level professionals more than in the past, changing support staff ratio to providers, or having nurses handle more of the functions of case management.

**Q.** Where do you see things going in terms of community-based medicine?

**A.** We have some arrangements with managed care organizations and we are seeking others. This is a practical response to the changing medical marketplace. We are not competing with HMOs, but we are competing with other organizations that want to be providers for HMOs, such as a family practice group. To do this effectively, we will have to reduce costs. I don't think that people understand that we are different from a private doctor's office or a hospital. We fall some place in the middle. We do have facility fees and overhead, and we

do provide a comprehensive range of support services. So our cost structure is different.

**Q.** It sounds like these support services may be vulnerable to cost cutting. But aren't those services essential in your community?

**A.** Yes, we have a lot of high-risk patients and those support services help keep

**Q.** I noticed in your literature that your rates of immunization are fairly high—over 70 percent. How is it that you're doing a better job than some other agencies?

**A.** We have been very aggressive, and part of that is because with the help of state dollars we've been able to have an immunization nurse.



Funds from "Building a Healthier Tomorrow"—Plainfield Health Center's first-ever capital campaign—will be used to build and equip a 32,000 square foot, state-of-the-art health care facility (pictured in the artist's rendering above), which will consolidate all of the Center's services under one roof.

people in the system. They get women into prenatal care early, they keep people out of hospital emergency rooms, and they get people in for HIV testing. We don't want to give up doing these things, but we will have to be more creative about how we do them. It may mean networking and sharing services with other providers in the community, or it may mean a number of agencies using the same outreach worker.

We've established our protocols with support from pediatricians, and nurses have been able to give children immunizations whenever they come in to the center. We also go out into the community. We work with the school system, and do a back-to-school immunization night every year free of charge. We go to day care centers, the welfare office, and other places and set up immunization clinics.

*The emphasis today is on competition, efficiency, and reduction in costs. Community health centers are going to have to meet these criteria.*

**Q.** Many HMOs say they want to do preventive medicine and case management, but in essence you've been doing these things for years.

**A.** Yes, but the reimbursement rates are not going to support that system. HMOs are mandated to provide certain health support services, some of which they provide on their own, and some of which they provide through contracting with organizations such as ours. All this is really very new, and on all sides we're feeling out what is realistic and what is not. As a community-based agency, what we'd like to see is that the playing field be level from the standpoint of what the required services are, who is going to provide them, and what the reimbursement will be for those services.

**Q.** We are seeing some dramatic cutbacks in Medicaid funding. What impact is that having on your organization?

**A.** It's going to impact us in terms of the scope of services we can provide. It will put more emphasis on us in terms of private fundraising, but a lot of those dollars are not readily available. More importantly, we are going to have to expand our service area through advertising, marketing, and new services like ophthalmology, to change our payer mix. Right now, we serve a population that is heavily uninsured and Medicaid. In order for us to insure our revenue stream we are going to have to increase our payer base while maintaining access for the medically underserved.

**Q.** During the Florio administration, when the state was trying to develop a comprehensive health plan, community health centers often were talked about as vital delivery systems for health services. Has that view changed?

**A.** Today, I think the focus is switching from community health centers to HMOs

connected with community health centers, PPOs, and private practitioners. But clearly the emphasis today is on competition, efficiency, and reduction in costs. Community health centers are going to have to meet all those criteria if they are to remain viable.

**Q.** There's been talk in some circles about using nonprofit organizations as vehicles for privatization of health care now provided by counties or municipalities. Do you see this happening in New Jersey?

**A.** The privatization concept has been raised in the state, but I have not heard it discussed in any depth. That may be a good way, and it certainly would be good for us. I see no reason why an organization like ours could not pick up services that some municipalities now provide, such as immunization clinics or sexually transmitted disease clinics. In small communities, like Plainfield, that kind of duplication is not cost effective.



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## New Jersey transplant programs: Alive, well, and growing

*Diane Haring Cornell*

New Jersey-based health care programs suffer from an image problem. Too often our citizens are wooed away by the bright lights and more established programs of big cities to our north and west. In spite of the long shadows cast by New York City and Philadelphia, the state's organ transplant programs are alive, well, and growing. In fact, New Jersey physicians not referring transplant candidates to in-state programs may be doing these patients a disservice.

All four of the hospital-based transplant programs have seen rapid expansion as their reputations for quality care grow. Newark Beth Israel Medical Center's Cardiac Transplant Program, the only one in the state, recently was granted Medicare approval, a designation that places the program among a select group nationwide. The seven-year-old Liver Transplant

Program at UMDNJ-University Hospital in Newark recently was granted approval to perform pediatric liver transplants. Last year, the program at Camden's Our Lady of Lourdes Medical Center expanded to include



*Transplant surgeon Stuart Geffner, MD (left), and chief surgical resident Michael Bilof, MD, perform a life-saving kidney transplant at Saint Barnabas Medical Center.*

simultaneous kidney/pancreas transplants as did the Renal Center at Saint Barnabas Medical Center. And, the renal transplant programs at Saint Barnabas and Newark Beth Israel Medical Center both recently reached an important milestone—their 1,000th kidney transplant.

In addition, continued refinements in immunosuppression have improved survival rates and lessened the number of rejection episodes. New agents used by virtually all the transplant centers include a new formulation of cyclosporine, Neoral®, which is better metabolized; the new drug Cellcept® (mycophenolate mofetil), which has replaced azathioprine because it allows physicians to reduce the amount of prednisone given to patients; and Prograf® (tacrolimus), which helps fight acute rejection. These new agents are heralded as safer, more effective, and more selective than their predecessors.

The only roadblock standing in the way of the collective programs even greater success is the availability of viable donor organs. "Nationwide, there are 44,000 people waiting for organ transplants," says Mark Smith,



PhD, executive director of The Sharing Network, a federally designated organ procurement agency serving north and central New Jersey. "Of those, about 3,000 to 4,000 people will die before an organ becomes available." In New Jersey, there are 800 people waiting for organs. Last year, says Dr. Smith, 34 people on the list died before a suitable donor was found.

According to Dr. Smith, the country's aging population has caused the numbers of potential candidates to increase, and improvements in technology have enabled physicians to accept older patients for transplantation. Meanwhile, he says, donations have remained stagnant.

In 1995, 114 New Jersey families agreed to donate their loved-ones organs, enabling doctors to perform 246 transplants. Most donors are victims of head trauma from motor vehicle accidents, gunshots, or brain hemorrhages.

In particular, African-American donors are needed. It has been found that minorities are less likely to donate a family member's organs because they distrust the medical establishment and they have a fear of being pronounced dead prematurely.

The overall organ shortage, and that of African-American donors, in particular, is felt most severely in the kidney transplant programs. Research has shown that minorities suffer disproportionately from end-stage kidney disease. All the kidney programs now are making a concerted effort to expand their living-donor programs in an effort to ease the shortage of cadaveric organs.

It also is hoped that some relief may come with the 1995 Donor Enhancement Act, which ensures that all hospital deaths of those age 75 years and younger are reported to an organ procurement agency for evaluation for potential donors. The specific requirements of the donor act will not be published until later this year.

## Southern New Jersey Artificial Kidney and Transplant Center Our Lady of Lourdes Medical Center

The Our Lady of Lourdes Medical Center's renal transplant program received approximately 100 referrals last year. Of those referred, 43 people received a kidney transplant. In the first six months of this year, 14 kidney transplants were performed and four pancreas/kidney transplants were done.

Most people who received a kidney transplant experienced renal failure caused by glomerulonephritis or diabetes, according to John Capelli,

MD, the program's medical director. About 55 percent of recipients are male and 45 percent are female.

The majority of the patients are 18 to 35 years old; about one-half of the recipients are white and a little less than one-half are African-Americans.

The one-year patient survival rate at the Medical Center is 94 percent; allograft survival is 79 percent. For three years, the survival rate for patients is 88 percent and for the organ the rate is 67 percent.



John Capelli, MD

## UMDNJ-University Hospital Liver Transplant Program

This has been a busy year for University Hospital's Liver Transplant Program, which was started in February 1989 and in June of this year performed its 200th transplant. In the first six months of this year, the program performed 26 liver transplants. In comparison, in all of 1995 they completed 37 transplants. In addition, the program recently was granted permission to begin pediatric transplantations and performed its first transplant in June on a six-year-old girl. The program also performs combined liver and kidney transplants on a case-by-case basis; it has performed one transplant so far this year.

About 150 to 200 people a year are referred to the program for evaluation and treatment, says the director, Baburao Koneru, MD, professor of surgery and chief of the division of transplant surgery. The predominate reason recipients need a transplant is cirrhosis caused by hepatitis B and C and alcoholism. Most patients are in their 40s or 50s, but the program will perform transplants on patients up to age 70 years. About 60 percent of the recipients are male

and about 40 percent are female. Fifty-seven percent are white; 43 percent are minorities. The average wait for a donor is about four months, compared with about 1 year in New York City or Philadelphia.



*Baburao Koneru, MD*

The mean hospital stay has been 11 days, down from 35 days in 1993. This can be attributed to a new immunosuppression regimen. For the most part, Dr. Koneru says, cyclosporine has been replaced by Prograf®. The drug is more potent than its predecessor and can control rejection much better. It is perhaps the most important reason why hospitalizations after transplant have been shortened, Dr. Koneru explained. Although, he adds,

in randomized trials of cyclosporine and Prograf®, not much difference has been shown in patient and graft survival rates.

Cellcept® has replaced azathioprine in both liver and kidney transplants because it is more potent, has fewer side effects, and allows the amount of prednisone given to patients to be reduced. In children, only Prograf® and prednisone are used in immunosuppression.



## Newark Beth Israel Medical Center Heart Transplant Program

After a false start in 1986, Newark Beth Israel Medical Center reactivated the state's only heart transplant program in 1990 with a new director and staff. Of the 150 people referred to the program each year, about 35 to 40 patients are accepted, the others are helped with other interventions. The program is fairly liberal in selecting candidates, but is rigid in excluding those whose pulmonary pressure is greater than 3.5 Wood units. Poor pulmonary pressure has proved to be the single biggest predictor of morbidity and mortality after transplant.

After acceptance, some patients are removed from the candidate list because their symptoms improve, and 9 to 11 percent die waiting for an organ. The typical wait has been 77 days; the national average is 200 days. Mark Zucker, MD, JD, director of cardiothoracic transplantation, attributes the favorable timelag between listing and receiving an organ to fewer people on New Jersey's waiting list. In late August, there were just 6 people waiting to receive a heart. The facility's widespread application of mechanical cardiac assist devices also allows critically ill patients to be kept alive until a donor organ becomes available.

About 20 to 25 people are transplanted each year. The recipients are overwhelmingly men (3 to 1), in their late 40s or early 50s, though patients have ranged from 17 to 67 years old. Virtually all patients

are suffering from end-stage heart failure most commonly due to cardiomyopathy, but as the upper acceptable age of candidates for transplantation increases, Dr. Zucker says he is seeing more patients (2 out of every 3) with ischemic heart disease being referred and accepted. His patients are almost all (98 percent) from New Jersey. About 72 percent are white; 28 percent are minorities.



Mark Zucker, MD, JD,  
and Laszlo Fuzesi, MD

The program uses primarily male donor hearts and usually does only ABO blood typing and matching for weight and size compatibility. Although human leucocyte antigen (HLA) cross-matching has been found to be a good predictor of success, it is not routinely applied because a heart

needs to be harvested and transplanted within four hours.

The average length of hospital stay for the last 18 patients was 12.5 days, excluding 1 patient who remained hospitalized for more than 30 days. The Center's one-year survival is 87 percent; the five-year survival rate is 63 percent. The primary cause of death during the first year is right ventricular heart failure, infection, and rejection.

The hospital also began performing lung transplants on a case-by-case basis in June 1992. Last year five people received a lung transplant.

## Newark Beth Israel Medical Center Kidney Transplant Program

Newark Beth Israel Medical Center's kidney transplant program, which was responsible for the state's first living-related kidney transplant, recently celebrated its 1,000th procedure. Directed since its inception in 1968 by Hossein Eslami, MD, approximately 150 to 200 people a year are referred to the program. Of those referred, about 50 to 60 people a year eventually are transplanted.

In the first six months of this year, 18 people received transplants. Sixty percent of recipients are male and the average age is 50 years. About 45 percent of recipients are African-American, the highest number for any of the kidney transplant centers. Most people who need a transplant suffer from glomerulitis, an inflammation of part of the kidney's vascular system, and diabetic neuropathy.

The one-year survival rate for patients is 95 percent and the survival rate for the graft is 78 percent; 3-year patient survival rate is 92 percent; 3-year graft survival rate is 88 percent. The major cause of failure in the first year is rejection and infection.

Dr. Eslami has seen cancer occur in his patient population, usually during the fifth or sixth year

after transplant. The most common cancers have been skin malignancies, lymphomas of the central nervous system, lymphoproliferative disorder, a disease affecting the lymphatic system caused by the Epstein-Barr virus, and skin cancer. Dr. Eslami notes that transplant patients who develop skin cancer

have a better prognosis than the general population because the cancer seems to behave differently in recipients, and is not as lethal.

For most patients, the Center uses the immunosuppression regimen of prednisone, Cellcept®, and Neoral®.

If a recipient does not respond to cyclosporine and develops chronic rejection, Prograf® is used

to stabilize the patient.

In his years heading the program, Dr. Eslami has seen the positive effect that medicine's greater understanding of the immune system has had on the outcome for kidney transplant patients. "We used to go overboard with immunosuppression when rejection occurred in order to save the transplant," he says. "Today that is no longer the case."

The program currently is seeking approval to perform simultaneous kidney/pancreas transplants.



*Hossein Eslami, MD*



## The Renal Center Saint Barnabas Medical Center

The Renal Center program is the largest kidney transplant program in the state. Last September the Renal Center celebrated its 1,000th transplant.

The program began in 1968 when it performed the state's first renal transplant. It has grown significantly over the years; in the first six months of 1996 the Center evaluated 250 candidates for transplantation. Last year, of the 400 people referred, 106 people received a renal transplant and eight people received a simultaneous pancreas/kidney transplant. As of August, 90 kidney transplants were performed and six kidney/pancreas transplants were done. The wait for a kidney has been about 360 to 400 days, and about 8 percent of patients die waiting for a donor organ to become available, according to Shamkant Mulgaonkar, MD, clinical director of transplantation at Saint Barnabas Medical Center.

Seventy percent of the recipients are male and 20 percent are minorities, says Dr. Mulgaonkar. The average age of those transplanted is 38 to 40 years; the youngest patient was 8 years old and the oldest patient was 72 years old. The main cause for transplantation is diabetes, and in black patients, it is hypertension. As the protocols for kidney and pancreas transplantation become more and more refined, the Center is correspondingly seeing the age of its recipients rise.

The one-year survival rate for patients is 98 percent; the survival rate for allograft transplant is more than 90 percent. Three-year patient survival rate is 96 percent.

All 12 kidney/pancreas transplants have been successful. This program was started in 1995. The

Center has found that with cadaveric kidney transplants, a good predictor of long-term outcome depends on how quickly the kidney functions once implanted. "The longer the kidney stays in shock, the worse the longevity," comments Dr. Mulgaonkar. Patients whose transplanted kidneys begin functioning immediately have less rejection episodes and need only moderate immunosuppression, he says.



*Shamkant Mulgaonkar, MD*

The average hospital stay is 8 days for a cadaveric transplant and 6 days for a living-related recipient. Those patients undergoing a simultaneous kidney/pancreas procedure have been averaging 15 days hospitalization.

The immunosuppression regimen for most patients is prednisone, Neoral® and Cellcept®. The first episode of rejection is treated with high doses of steroids; the second episode of rejection is fought with monoclonal antibodies for ten days. The Center does not rely heavily on Prograf®, finding it causes more diabetes in patients who are transplanted.

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## She's got heart: A patient's story

*Diane Haring Cornell*

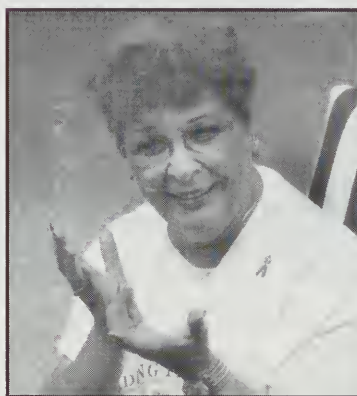
For her 40th birthday, Ann O'Hanlon of Saddlebrook gave herself and her family a present: a complete physical. But Mrs. O'Hanlon, who always had experienced heart palpitations, or as she puts it, "a racy heart," did not fare well. She did have an inkling something wasn't quite right. At home she was finding it increasingly difficult to raise her arms or lift her legs. But she had no idea how bad the situation was or was to become.

After an abbreviated stress test, (the physician quickly ended it because he thought she was going to "arrest"), Mrs. O'Hanlon was diagnosed with nonischemic cardiomyopathy, a disease of the heart muscle whereby the pumping power of the heart is severely reduced. Her condition, the cause of which is unknown, resulted in an enlarged heart and ultimately to congestive heart failure.

Mrs. O'Hanlon recalls, "I was told I had the heart of a 90-year-old woman and that eventually I would need a transplant."

Doctors also told her that the procedure was not refined enough yet and that she should try to hold out as long as possible before subjecting herself to transplantation.

Mrs. O'Hanlon's condition continued to decline. During the time she waited for her transplant she saw the quality of life erode to the point where she was forced to spend her days and nights sitting on two floor cushions, leaning forward against her



living room couch. It was the only way she could take a breath of air. Her heart had become so weak that fluid accumulating in her lungs forced her to struggle for each breath. At night, her husband would rub her back to try to get her to relax enough so she could get some sleep. She could not lay on her back and continue to breathe.

"If I went out, someone always had to be with me," she

says. Afterward, she would need to rest, exhausted by the simple chore of running an errand.

She was hospitalized many times for congestive heart failure. Four times her family was told she wouldn't make it through the night. But Mrs. O'Hanlon continued to fight.

Finally in 1991, after another bout of congestive heart failure her cardiologist told her it was now or never. Although she had known about the possibility of a



transplant for more than a decade, it still shook her to hear that the time had come.

"I never really thought it would be a reality for me," she recalls. She told her doctor she needed time to decide. "I was so overwhelmed that I told him I had to think about it and get back to him," she remembers.

On April 1, 1991, she went to Newark Beth Israel Medical Center to discuss heart trans-

plantation with Mark Zucker, MD, JD, director of the hospital's program. An evaluation was scheduled for April 20, but her condition worsened and her next visit was moved up to April 13. On April 26, she was approved for a transplant and given a beeper. The wait began.

In order to prepare her body for the surgery she had to inject herself twice each day with heparin, a blood thinner.

On May 19, a day she describes as a "beautiful, sunny Sunday after Mother's Day," the telephone call came. It was the transplant coordinator at the hospital. "She asked me what I

in her arms so they could rush her into surgery as soon as her donor heart arrived, Mrs. O'Hanlon began to feel dizzy. She had just finished signing all the consent forms for the surgery and was holding her husband's hand when the room started spinning. "I said to my husband, 'Jerry, I don't feel so good.' " Then everything went black. She had developed ventricular fibrillation. Physicians were able to resuscitate her.

At 10 P.M. she was wheeled into the operating room. The surgery performed by Laszlo Fuzesi, MD, surgical director of cardiac transplantation, lasted

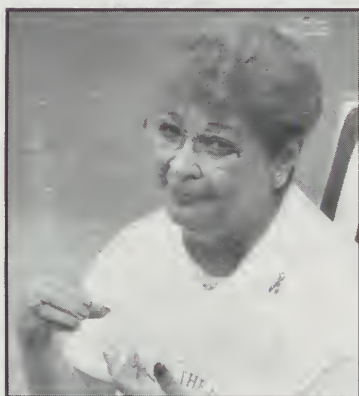
Her recovery was uncomplicated. On the third day, the nurse brought in a stationary bicycle to her room and although she couldn't do too much on it, it was a start on the road back to good health. By the next day she was up and around. Fifteen days after she was first hospitalized, Mrs. O'Hanlon and her husband took a one-mile walk around the lake in Saddlebrook Park. Not bad for someone who a little more than two weeks before could not take two steps without sitting or falling down.

Today, five years after her operation, Mrs. O'Hanlon is making up the time she lost to illness. Her days are spent happily visiting with her grown children and her eight grandchildren. She is an active volunteer at The Sharing Network, an organ procurement agency. She feels it is imperative that transplant recipients tell their stories so that prospective donor families understand what their gift could mean to someone.

She also counsels other heart transplant recipients, telling them, she says, that there was no pain during her recovery, just discomfort. "Dr. Zucker told me that root canal or a bypass is more painful than a transplant," she says, adding, "He was right."

"Sometimes I am so overwhelmed by the improvement in my condition that I still pinch myself everyday," she says. "I can't believe it. I feel better now than I have ever felt in my whole life."

**NJM**



Photos: © Conrad Gloos

was doing and I told her I was wishing and hoping for a heart. She said, 'Hang in there. I think we've got one for you. But don't get your hopes up because we can't get the entire donor family to agree. Don't eat anything and we'll call you back in an hour.' "

She arrived at the hospital about 4:30 P.M., and was admitted and assigned a room. At 8:30 P.M., as she was waiting with IVs

two hours and 15 minutes. At 3 A.M. when she opened her eyes, she was in an isolation room. As she scanned the room her gaze moved to the large glass partition that looked out onto the hospital corridor. She saw her husband and daughter standing there, waiting for her to wake up. She gave them a thumbs up and everyone started to cry tears of relief and happiness. The worst was indeed over.





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## SURGICAL TREATMENT OF EPILEPSY: ROBERT WOOD JOHNSON EXPERIENCE

*Richard M. Lehman, MD  
Tristram Horton*

**Dr. Lehman is associate professor, Division of Neurosurgery, UMDNJ-Robert Wood Johnson Medical School. Mr. Horton is a graduate of Rutgers University.**

The history of surgical treatment for recurrent seizures goes back to ancient times, when the condition was believed to be the result of evil humors within the cranium.<sup>1</sup> Such evils warranted early attempts at trephination.

Over a century ago, neurologist Hughlings Jackson introduced the concept of seizures arising from a focal area of abnormality in the brain. In 1886, Sir Victor Horsley performed the first surgical procedure based on this concept. The patient had been diagnosed and extensively studied by Jackson.<sup>1</sup> Treatment has since progressed to the point that neurosurgical procedures currently are performed for intractable epilepsy stemming from a variety of etiological and pathological factors.

Seizures are the most common neurologic condition re-

quiring hospitalization.<sup>2</sup> One out of ten people will have an epileptic seizure at some point.<sup>3</sup> Seizures recur in almost one-half of these patients and become intractable in 5 to 15 percent of the cases, despite thorough medical therapy. A 1990 estimate quoted a figure of 400,000 cases of intractable epilepsy in the United States, with 10,000 new cases diagnosed per annum. Recent studies suggest that as many as one-half of these patients could benefit substantially from surgical intervention.<sup>4</sup>

Surgery as a definitive treatment for intractable epilepsy is an alternative primarily concerned with individuals with focal epilepsy as opposed to generalized epilepsy.<sup>5</sup> Focal seizures, also known as partial seizures, are the manifestation of a focal origin. They are idiopathic in almost two-thirds of patients, but may include pathology secondary to complications of febrile seizures in childhood, cerebrovascular disease, brain tumors, head trauma, developmental disorders, and central nervous system infections.

Computer-assisted tomography (CT) and magnetic resonance imaging (MRI), as well as scanning by single photon emission computer tomography (SPECT) and positron emission tomography (PET), have significantly improved the ability to evaluate and pinpoint the problem area of the brain responsible for seizure onset. Computer analysis of prolonged video-EEG monitoring provides valuable data on the brain's abnormal electrical activity that is indispensable in determining the focus of seizure onset as well as surrounding epileptogenic brain tissue required to propagate the seizure. These modern techniques have resulted in more accurate and precise surgery for removal of the tissue causing epileptic seizures; such advances have yielded a greater percentage of seizure-free or rare-seizure patients than in the early decades after World War II.

Despite the obvious indications and needs, the efficacy of surgery for treatment of intractable epilepsy remains a question in the minds of some neurologists. Full remission of



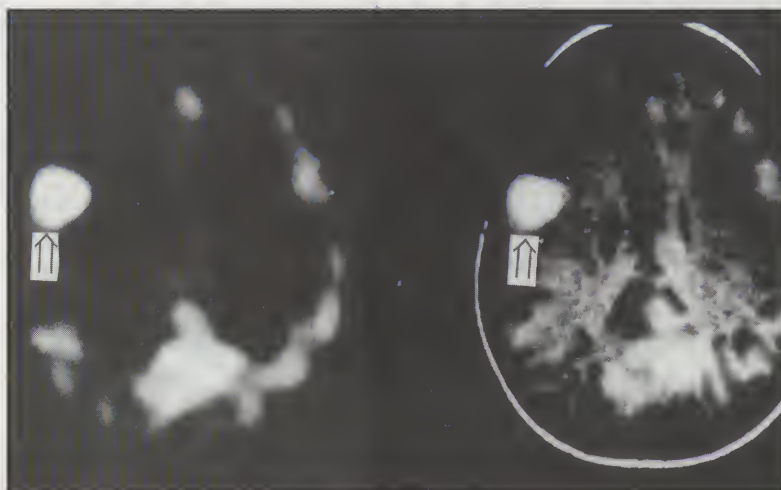
*The results of our study of the surgical treatment of epilepsy patients are in keeping with major epilepsy centers. This illness is a window to understanding the function of the brain.*

seizures after two years of anti-convulsant drug therapy occurs in only 5 to 8 percent of patients.<sup>6</sup> Such poor medication results justify the need to assess other approaches to the management of this problem. Continuing prospective studies comparing surgery and the newer anticonvulsants must be conducted to evaluate the benefits of surgery for intractable epilepsy, and to educate both members of the medical and nonmedical community.

This paper represents an initial report of surgical cases for the treatment of epilepsy at Robert Wood Johnson University Hospital (RWJUH).

#### **Patients and methods.**

Eighteen patients (with intractable focal epileptic seiz-

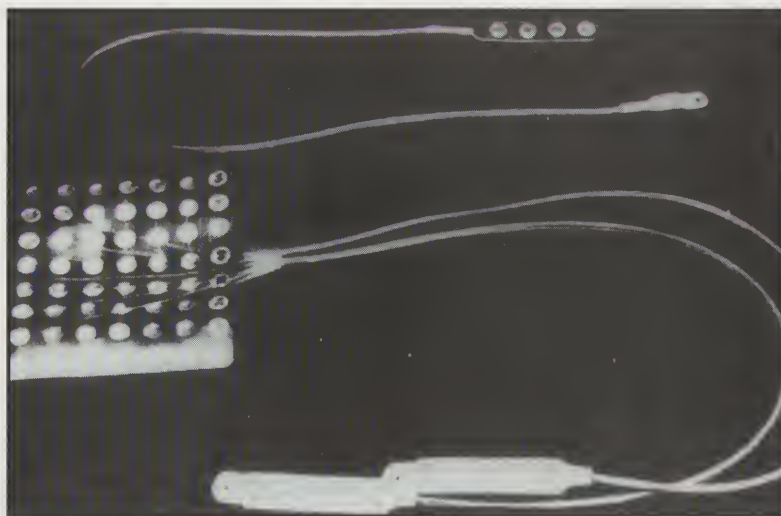


**Figure 1.** SPECT scan, increased flow, ictal phase, at seizure focus (arrows).

ures) were assessed at RWJUH between March 1992 and December 1994. Seventeen patients were treated by surgical resection. One of the patients was monitored after placement of subdural electrodes and surgery was deferred, having successful sur-

gery after completion of this paper.

Preoperative video-EEG monitoring was performed using 16 channel recordings. Epileptiform ictal (seizure) and interictal (between seizures) abnormalities were recorded in 12 patients. Subdural electrodes for definitive electrophysiologic localization were inserted in 6 patients. Detailed neuropsychological evaluations were carried out on all but 3 patients pre- and postoperatively. The intracarotid amytal test with video-EEG monitoring for speech and memory localization was performed in 10 patients. Arteriovenous digital subtraction angiography (DSA) was performed for diagnosis and anatomical mapping. All



**Figure 2.** Subdural grid for chronic intracranial EEG.

*With the application of computers in brain imaging and the analysis of long-term EEG-video monitoring, surgery can be performed on more patients with intractable focal epilepsy.*

patients had preoperative MRI studies. CT scanning was used for localization of subdural electrode contacts during intracranial EEG monitoring, and in the immediate post-operative period for assessment of the resection site.<sup>7</sup> SPECT scanning was performed in several cases to demonstrate focal brain hypometabolism compatible with the seizure focus. These findings were coordinated with EEG data. Electrocorticography (ECoG) was performed in those patients, when preoperative intracranial recordings had not been performed. Cortical mapping with bipolar stimulation was carried out in some cases in the awake state, to facilitate the

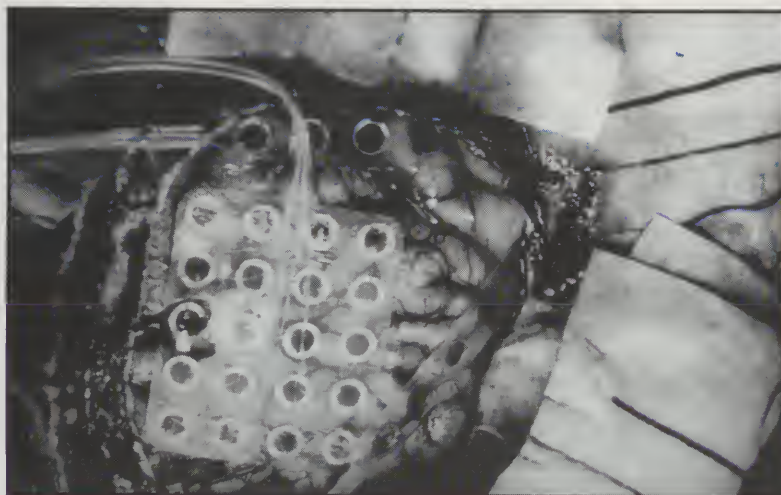
avoidance of speech or motor cortex. Postresection ECoG was not performed, but followup EEG studies were conducted in 14 of the 18 patients.

**Results.** All but one of the 12 females and 6 males were right-handed. Mean age of onset of seizures was 18.1

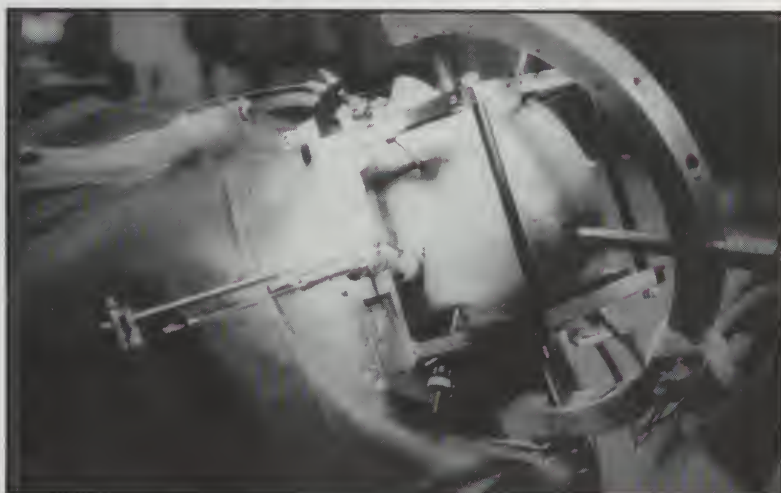
years, with a range of 18 months to 47 years. The average age at surgery was 30.2 years, ranging from 5 to 57 years. The mean duration of followup was 13 months, with a range of 1 month to 3 years.

The 18 patients had intractable focal epileptic seizures of varying clinical history. Seven patients were predisposed to seizures by tumors of the brain. In 4 patients, the suspected etiology was a prior meningitis, while in 3 patients, the causation may have been a febrile seizure early in childhood. The etiology of the remaining 4 patients is unknown, with 1 patient having grand mal seizures at a young age.

The epileptogenic area was on the right side of the brain in nine patients and



**Figure 3.** Grid-in site.



**Figure 4.** Insertion of intracerebral electrode to anterior medial hippocampus.



*The goal of treatment of patients with epilepsy is cessation of seizures because chronic recurrent seizures pose a number of threats to the safety and well-being of the patient.*



**Figure 5.** Interictal epileptiform sharp wave with phase reversal localizing a common electrode.

in the dominant, left cerebral hemisphere in nine patients. In six patients, the focus of seizure activity was in the left temporal lobe; in five patients, the seizure activity was in the right temporal lobe; in four patients the seizure activity was in the right frontal lobe; and in two patients, seizure activity was in the left frontal lobe. In one patient, a focal area of seizure onset was not clear, as this patient's seizure disorder had evolved from an original focal disorder to a generalized state. In this particular patient, the entire left hemisphere

represented a region of potential epileptiform tissue.

Patients were identified by seizure pattern, neurologic and neuropsychologic examinations, radiologic studies, EEG delineation of seizure activity,

pathology, results of treatment, and complications. Patient followup and review of results continues, with the mean duration of 13 months. Outcome and followup are graded according to Olivier's classification as well as Rasmussen's classification (Table). There were no deaths in the study. One patient developed a CSF leak, which was repaired. Later, an epidural abscess was evacuated. This patient with mental retardation had relief of seizures, but a much worse neurological deficit. Fifteen patients had no neurological deficit following surgery. One patient with temporal lobe epilepsy had a postoperative visual field-cut. There was no

### Table. Olivier and Rasmussen classifications.

#### Olivier's Classification:

A: Seizure-free or rare seizure	N = 14
B: Worthwhile seizure reduction (greater than 50%)	N = 2
C: No worthwhile improvement (less than 50%)	N = 1
Total:	N = 17

#### Rasmussen's Classification:

0: Patient seizure-free following discharge	N = 14
1: No seizure after early run-down period of seizures	N = 0
2: Late recurrence of seizures	N = 0
3: Having two or less attacks per year	N = 0
4: Moderate or no reduction in seizures	N = 3
Total:	N = 17

*With the advent of modern imaging, computer analysis, and storage of EEG data, localization of seizure focus and associated structural abnormalities has become possible.*

permanent deficit in cognitive function or IQ in those patients who were neuropsychologically evaluated following their surgery.

**Discussion.** The goal of treatment of patients with epilepsy is the cessation of seizures. Chronic recurrent seizures pose a number of threats: impairment of brain function and maturation as seen in IQ and cognitive function testing; the stigmatization and loss of identity as family member, peer, and employee; and a prospective risk of sudden death of 6 to 19 percent, which increases with each medication administered.<sup>8,9</sup>

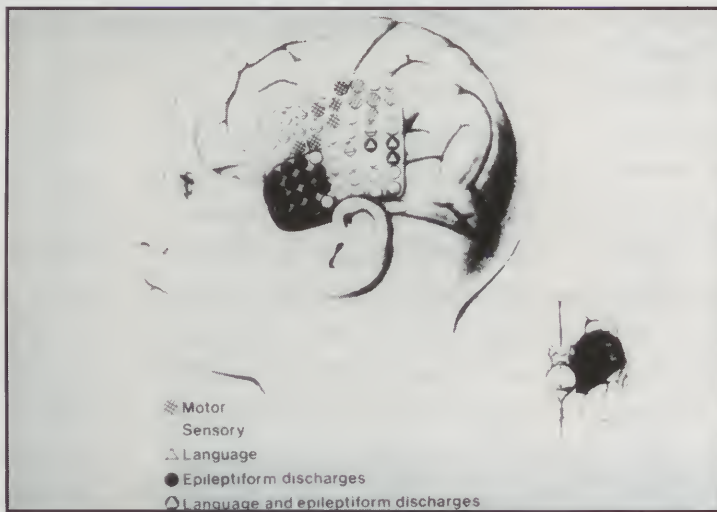
Occasional seizures on medication with dose-related sedation or cognitive side effect should not be considered appropriate management. Cessation of seizures within the first year is the best indicator of antiepileptic drug efficacy.<sup>10</sup> Efficacy of first-line medications after two years is remote, so that low-risk surgery should be considered.

With the advent of modern imaging, computer analysis, and storage of EEG data, localization of seizure focus and associated structural abnormalities has become possible. This has lead to a marked increase in patients undergoing surgery for intractable epilepsy with good results.<sup>11</sup> Many patients undergoing a phase 1 evaluation, consisting of clinical

during the interictal phase, while the ictal phase SPECT will reveal increased blood flow and metabolism (Figure 1). A new technique of magnetoencephalography can localize the dipole of epileptiform activity.<sup>13</sup> This study can be superimposed upon MRI images or coordinated with event-related fast MRI images, to localize functionally important areas of

the brain, i.e. speech, motor.<sup>14</sup> Prior to surgery, injection of amobarbital into the carotid artery on one side and then in 30 minutes on the other side under EEG monitoring produces a temporary paralysis of each cerebral hemisphere. During that time, speech and mem-

ory are tested to determine which hemisphere is dominant for speech and the ability of the contralateral temporal lobe to support global memory after the ipsilateral temporal lobe is removed. Global and material-specific memory is tested with sentences, objects, and words before, during, and after the



**Figure 6.** Subdural grid contacts used for stimulation and mapping speech area.

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examination, imaging, scalp EEG, and neuropsychological examination, that reveals concordant data, may come to surgery without invasive chronic intracranial EEG recording.<sup>12</sup> Functional imaging by PET and SPECT will reveal decreased blood flow or metabolism, in the area of the seizure focus



## *Chronic recurrent seizures pose a number of threats. Cessation of seizures within the first year is the best indicator of antiepileptic drug efficacy.*

injection of the amobarbital. The medial temporal lobe structures, which are the source of pathologic alteration and seizure focus in temporal lobe epilepsy (the most common and intractable focal epilepsy), will reveal memory deficits on routine testing that will be accentuated when the other temporal lobe is inactivated by amobarbital. This test also is referred to as the WADA test.<sup>15</sup> Passing the WADA test refers to the ability of the contralateral temporal lobe of the intended surgical side to support global memory.

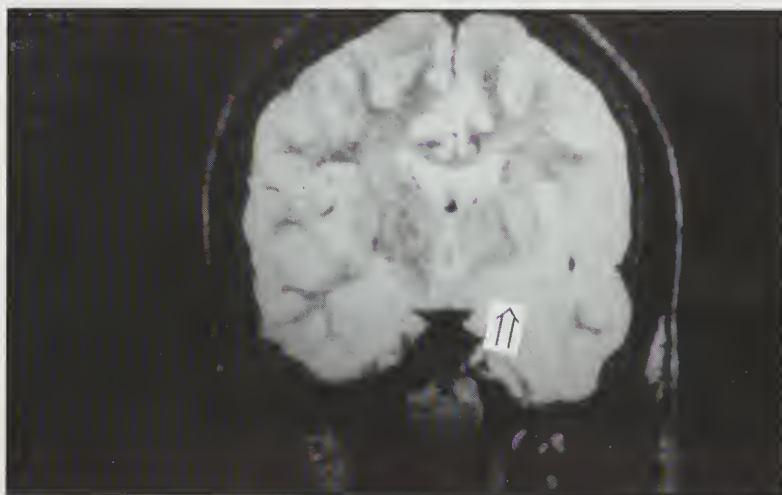
When EEG, imaging, and neuropsychological examinations are discordant, chronic intracranial recording (with depth electrodes, subdural electrode strips, or in the extra-tem-



**Figure 7.** Operative direct stimulation of motor and sensory face cortex.

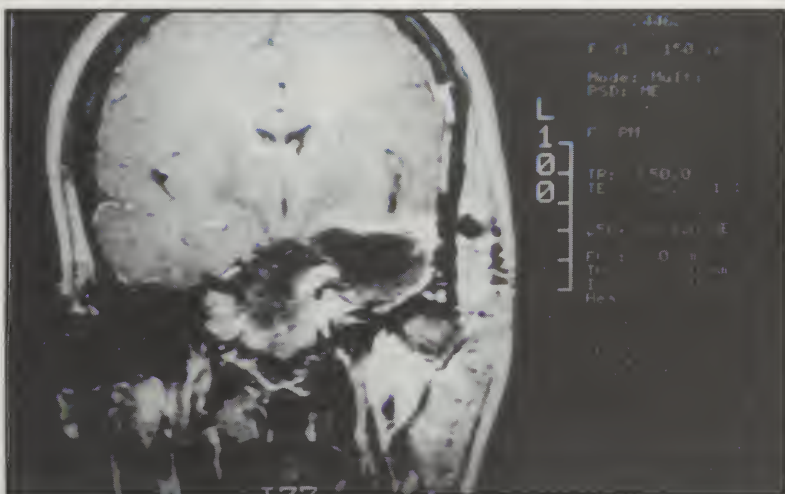
poral areas with grid electrode contacts) is warranted to lateralize and localize the electrophysical focus of the seizure (Figures 2-5). Mapping of motor and speech areas can be carried out by stimulating the grid contacts (Figure 6). At

surgery, the grid is removed and the definitive excision is made more safely. In those patients not requiring preoperative invasive recordings, ECoG is performed at surgery to confirm extent of cortical resection, functional mapping of speech, and motor function. The latter patients are operated on in an awake state under local anesthesia (Figure 7, note ticket 4—motor face and ticket 5—sensory face). Preoperative intracranial recording for localization and lateralization was performed in 6 of the 11 patients with temporal lobe epilepsy. All had consistent unilateral medial temporal lobe ictal onset. Determining the extent of resection of the medial structures, i.e. amygdala,



**Figure 8.** MRI, preoperative sclerotic medial temporal lobe (bright on T2—arrow).

*Postoperatively, patients are maintained on anticonvulsants at nontoxic levels, usually monotherapy for two years and no longer than five seizure-free years before medicine is discontinued.*



**Figure 9.** MRI, coronal T1, resection medial temporal structures.

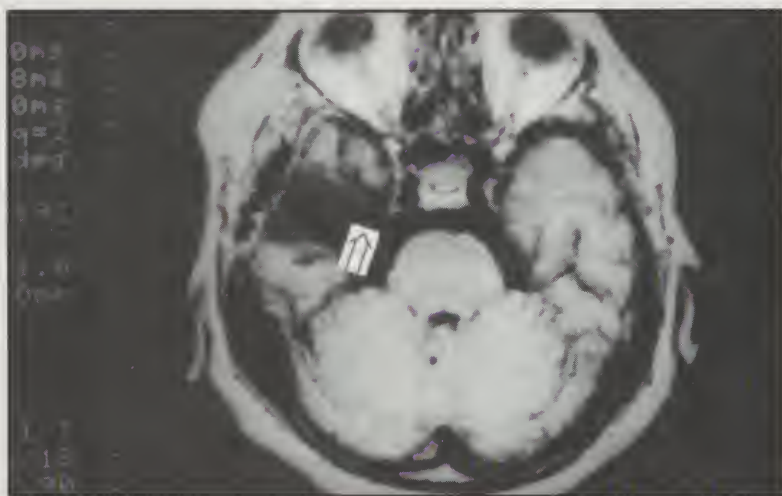
uncus, hippocampus, and para hippocampal gyrus is crucial to obtaining a seizure free patient (Figures 8, 9, and 10).<sup>16</sup> All but 1 of our patients with temporal lobe epilepsy is seizure-free 2 to 32 months after surgery.

The surgical treatment of epilepsy is directed: to determine the onset or pacemaker of the seizure, to the area of epileptogenic tissue required to propagate the seizure, and to the amount of brain required to be resected to rid the patient of seizures.<sup>17</sup> This area should include dysfunctional or potentially epileptogenic tissue. There are two general corollaries in epilepsy surgery: more extensive resection generally is more effective and in mesiotemporal epilepsy, extent of mesiobasal resection is the most important

determination of favorable outcome. In patients with structural brain lesions, i.e. tumor, hamartoma, AVM lesion resection generally is enough to control seizure, but may require additional areas of epileptogenic tissue as revealed by ECoG to be resected for a seizure-free outcome. All of our frontal lobe

epilepsy cases arose about a lesion; two cases have occasional postoperative seizures, but worthwhile improvement. Surgical patients failing to have relief of seizures most likely are the result of insufficient resection at the first operation or there was an error in electrophysiologic localization.<sup>2</sup>

Postoperatively, patients are maintained on anticonvulsants at nontoxic levels, usually monotherapy for a period of at least two years and no longer than five seizure-free years before the medicine is tapered and then discontinued. Some patients always may require medication. EEG recordings done over the first one or two years revealing absence or paucity of interictal activity is a marker for absence or rare



**Figure 10.** MRI, axial T1, resection medial temporal structures.



## *Future progress in functional imaging using photons, MRI spectroscopy, fast MRI, and magnetoencephalography will widen our understanding of epilepsy.*

seizures occurring following surgery. This has been noted in our series as previously reported.<sup>18</sup> MRI postoperatively will delineate extent of resection and removal of epileptiform tissue as revealed on intracranial recordings (Figures 9 and 10). Over the next year improvement in cognitive and IQ testing, as well as patient self-esteem will be noted, which correlates with marked reduction or absence of seizures.<sup>19</sup> This, in turn, will be reflected in school achievement, employability, opportunity to obtain a driver's license, and family member and peer participation. Psychosis and personality trait disorders are not affected by surgery. Depression, the most common psychological disorder, improves with a seizure-free state.<sup>20</sup>

Results of surgery are classified by several methods, but generally are categorized as seizure-free, rare-seizure, worthwhile reduction (75 percent), and moderate or not worthwhile reduction. Our best results occur in temporal lobe, lesional, and hemispherectomy (with major involvement of one hemisphere in young children) resections. Seizure free or marked reduction of seizure

occurred in 85 percent of our patients. Palliative surgery by sectioning of the corpus callosum will reduce the disabling drop-attacks in 80 percent of patients with generalized seizures and atonic or tonic falling.<sup>21</sup> Postoperative seizure-free periods at 6 and 12 months predict 90 percent probability at two years of being seizurefree. Extratemporal resections in frontal and parieto-occipital lobes is fraught with size of lobe (frontal), extent of epileptiform activity, and eloquent cortex that cannot be sacrificed.

**Conclusion.** Our results in the surgical treatment of epilepsy of 18 patients are in keeping with major comprehensive epilepsy centers in North America.<sup>23</sup> Progress in diagnosis and surgical treatment of epilepsy has improved in the past 10 to 12 years based on computer applications to imaging and analysis and storage of electrical data. Future progress in functional imaging using photons, MRI spectroscopy, fast MRI, and magnetoencephalography will widen our understanding in epilepsy. This illness truly is a window to understanding the function of the brain.<sup>24</sup>

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Jane E. Miller, PhD

## AIDS KNOWLEDGE AMONG NEW JERSEY ADULTS

*Data were collected from New Jersey adults. Most respondents know the major means by which the disease is transmitted and that a cure and vaccine are not available.*

**Dr. Miller is affiliated with the Institute for Health, Health Care Policy, and Aging Research and with the Department of Urban Studies and Community Health, Rutgers University, New Brunswick.**

From its first appearance in the early 1980s until 1994, acquired immunodeficiency syndrome (AIDS) has afflicted 410,000 persons in the United States.<sup>1</sup> By 1992, AIDS ranked as the eighth leading cause of death, and was the leading cause of death among black males aged 25 to 44 years.<sup>2</sup> The disease accounted for 33,566 deaths in 1992; 1.5 percent of all deaths that year. There are significant gender and race differentials in the impact of AIDS. In 1992, males were nearly seven times as likely as females, and blacks nearly four times as likely as whites, to die from the disease.<sup>2</sup>

In New Jersey, AIDS is of substantial concern. With an

incidence of 63 cases per 100,000 persons in 1994, New Jersey ranks third behind only Washington, DC (245 cases per 100,000 persons) and New York (82 cases per 100,000 persons) in the incidence rate of the disease.<sup>3</sup> Rates for minority groups are considerably higher than the average, with 373 cases per 100,000 blacks and 154 cases per 100,000 Hispanics reported in New Jersey in 1993.<sup>4</sup> Through late 1994, 24,307 New Jersey residents had contracted AIDS.<sup>1</sup>

Since prevention remains the only effective intervention for AIDS, education is critical. It is unlikely that appropriate behavioral change will occur without an understanding of AIDS and the means of human immunodeficiency virus (HIV) transmission.<sup>5</sup> To design effective educational interventions, it is important to have information about which aspects of the disease are least understood as well as which groups of the population are least informed.

This paper analyzes data from approximately 300 adults concerning their knowledge of AIDS, how it is transmitted, and the current state of medical interventions to prevent or cure the disease.

**Data and methods.** Data were collected from 292 adult New Jersey residents in fall 1995 by students in the public health program at Rutgers, the State University of New Jersey. Respondents were selected at random from all areas of the state according to criteria designed to reflect the demographic composition of the state. Compared to the entire adult population of the state, the study sample over-represents members of minority groups, persons under the age of 30 years, and individuals with more than a college education (Table 1).<sup>6</sup>

Questions used in the survey were adopted from the 1992 National Health Interview Survey (NHIS) *Supplement on AIDS Knowledge and Attitudes* and are shown in Table 2.



*Misconceptions about being infected with the HIV virus without having the disease and about transmission through casual contact were relatively common.*

**Table 1.** Sociodemographic composition of the sample and the New Jersey adult population (percent).

	Study sample (1995)	New Jersey adults (1990 census)
<b>Age (years)</b>		
18-29	41.4	24.1
30-49	32.1	40.0
50 or older	26.1	35.9
<b>Sex</b>		
Male	48.6	48.3
Female	51.4	51.7
<b>Race</b>		
African-American	25.4	12.5
Asian	13.9	3.3
White	51.0	80.9
Other	9.7	3.4
<b>Hispanic origin</b>		
Yes	17.5	8.2
No	82.5	91.8
<b>Educational attainment</b>		
Less than high school	8.2	23.0
High school, no higher	28.5	31.4
More than high school	63.2	45.6
Number of persons	292	5,831,524

**Source:** U.S. Department of Commerce, Bureau of the Census, 1993. *General Population Characteristics—New Jersey*, U.S. Government Printing Office.

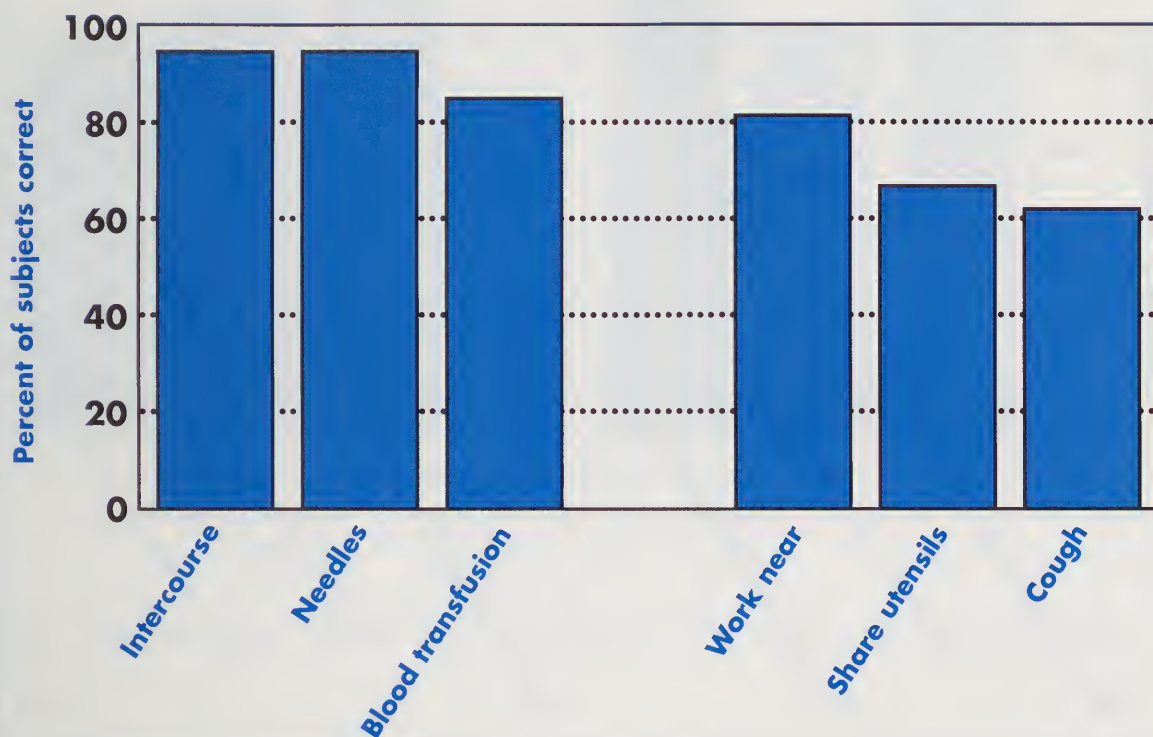
Wording of the questions was the same as in the national survey except for the question on blood transfusion, which was changed to reduce ambiguity

about the intent of the question. General AIDS knowledge was assessed with six questions concerning characteristics of the disease, its effects on infected

persons, and availability of preventive and curative interventions against the disease. Knowledge of AIDS transmission was assessed with six questions concerning likely means of transmission (sexual intercourse, sharing of intravenous (IV) needles, and blood transfusion) and unlikely means (casual contact such as working near, sharing eating utensils, or being coughed or sneezed on by someone with the HIV virus). Subjects also were asked to indicate from which of 13 sources of information they had learned about AIDS in the preceding month. Total number of sources reported by each respondent was grouped as none, 1-2, 3-4, and 5 or more sources.

**Results.** Most people had a good understanding of the ways AIDS most likely is to be transmitted (Figure 1). Ninety-five percent of subjects knew that the AIDS virus can be passed along through sexual intercourse or by sharing needles with another person, while 88 percent knew that AIDS can be transmitted by receiving a blood transfusion from an infected person. Misconceptions about transmission of the

**Figure 1. Percent of subjects answering correctly to AIDS transmission questions, 1995.**



AIDS virus through casual contact were more common. Although more than 80 percent knew that it is unlikely that someone could acquire AIDS by working near someone with the AIDS virus, only 70 percent knew that acquisition of AIDS by sharing plates, cups, or other utensils with an infected person is unlikely, and fewer than two-thirds knew that AIDS cannot be transmitted via coughing or sneezing.

In terms of general AIDS knowledge (Figure 2), virtually everyone surveyed had heard

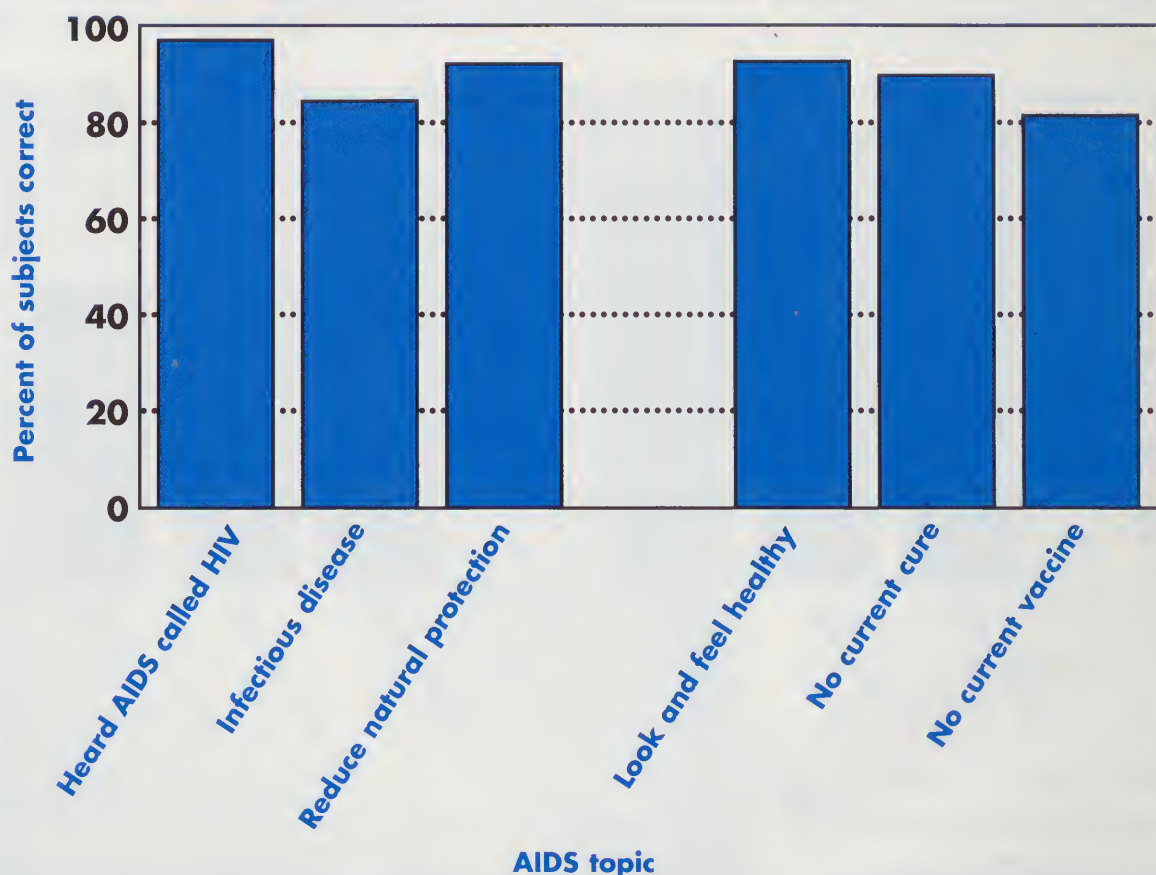
the AIDS virus called HIV, and over 90 percent knew that AIDS reduces the body's natural protection against disease, while more than 80 percent knew that AIDS is an infectious disease for which there is no vaccine or cure. Although nearly 90 percent knew that a person with AIDS can look and feel healthy, only 75 percent knew that someone can have the AIDS virus but not have the disease AIDS.

Knowledge levels about AIDS varied across sociodemographic groups. Figure 3 shows the

percentage of persons with a specified characteristic who answered at least 9 of the 12 AIDS questions correctly. AIDS knowledge was higher among younger subjects, with more than 90 percent of persons aged 18 to 29 years scoring at that level, compared to 83 percent and 62 percent of persons aged 30 to 49 years and 50 years or older, respectively. More than 86 percent of women answered at least three-fourths of the questions correctly, compared to 75 percent of men. Knowledge levels were



**Figure 2. Percent of subjects answering correctly to AIDS general knowledge questions, 1995.**



higher on average among white respondents than among minority racial groups, and among non-Hispanic than Hispanic respondents. Knowledge levels increased with level of educational attainment: only 54 percent of persons with less than a high school education answered at least three-quarters of the questions correctly, compared with 63 percent of high school graduates and 93 percent of persons with more than a high school education. Scores increased with the num-

ber of sources from which the respondents reported having obtained AIDS information in the month prior to the survey, from 62 percent of persons who reported no sources to 87 percent of persons who reported five or more sources. Groups that fared well overall were more likely to answer each specific question correctly. Differences across groups were larger for the topics that were least well understood, such as that AIDS is unlikely to be transmitted by casual con-

tact or that a person can be infected with the AIDS virus but not show signs of the disease.

**Discussion.** A survey of AIDS knowledge among New Jersey residents in 1995 demonstrated a high level of awareness of most attributes of the disease, although there were notable deficits in some topic areas and among some groups.

The good news is that the majority of respondents were aware of the major means by

which the disease can be transmitted and knew that neither a cure nor a vaccine to prevent the disease presently is available to the public. These are the most critical facts for motivating the types of behavior change that will effectively reduce the risk of AIDS transmission. The bad news is that misconceptions about being infected with the virus without having the disease and about transmission through casual contact were relatively common. These patterns are consistent with response patterns observed in a national survey of the same topics in 1992 (the

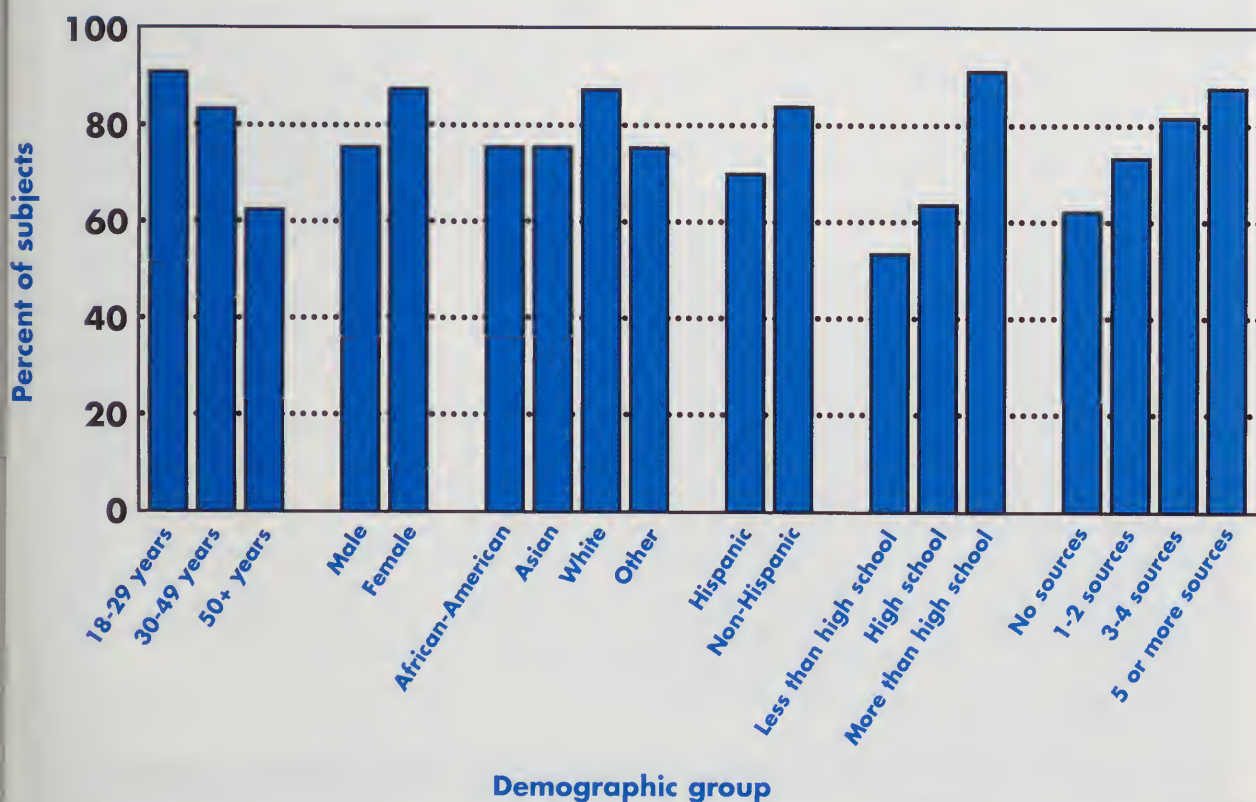
most recent year for which national data were available), although New Jersey subjects were much more likely to know that coughing and shared utensils are not ways by which the AIDS virus is transmitted.<sup>8</sup>

Our findings suggest several important considerations for education programs about AIDS. First, there is a particular need for more AIDS education among minority groups, men, and persons with lower educational attainment, since these groups were less likely to know the correct information about AIDS and also have relatively high rates of infection with the

AIDS virus.<sup>8,9</sup> Older adults also have a poorer understanding of AIDS, but are not at as high a risk of contracting the disease.

Second, misconceptions about transmission of the virus through casual contact (such as via cough or shared eating utensils) need to be corrected, so that infected persons are not discriminated against in the workplace, schools, or other community settings. People also need to be informed that infected persons can feel healthy and may not exhibit symptoms of the disease, so that those at

**Figure 3. Percentage of subjects who answered at least 9 of 12 questions correctly.**





risk do not wait until symptoms appear before they get tested or change their behavior to reduce the chances of spread-

ing the virus. Other studies suggest the need to provide culturally appropriate educational media for different racial and

ethnic groups in order for AIDS messages to reach and be accepted by members of these groups.<sup>10,11</sup>

**Table 2.** Questions used to access AIDS knowledge.

Correct answers are denoted in **BOLD** or marked with an **X**.

3. Have you ever heard the AIDS virus called by the name "HIV"?	<b>YES</b>	No	Don't know
4. For each of the following statements, circle whether you think it is true, false, or don't know.			
a. AIDS can reduce the body's natural protection against disease.	<b>TRUE</b>	False	Don't know
b. AIDS is an infectious disease.	<b>TRUE</b>	False	Don't know
c. A person can be infected with the AIDS virus and not have the disease AIDS.	<b>TRUE</b>	False	Don't know
d. ANY person with the AIDS virus can pass it on to someone else through sexual intercourse.	<b>TRUE</b>	False	Don't know
e. A person who has the AIDS virus can look and feel healthy.	<b>TRUE</b>	False	Don't know
f. There is a vaccine available to the public that protects a person from getting the AIDS virus.	True	<b>FALSE</b>	Don't know
g. There is no cure for AIDS at present.	<b>TRUE</b>	False	Don't know

---

5. How likely do you think it is that a person will get AIDS or the AIDS virus infection from:						
	<b>Very Likely</b>	<b>Somewhat Likely</b>	<b>Somewhat Unlikely</b>	<b>Very Unlikely</b>	<b>Definitely Not Possible</b>	<b>Don't Know</b>
a. Working near someone with the AIDS virus?	—	—	—	<b>X</b>	<b>X</b>	—
b. Sharing plates, forks, or glasses with someone who has the AIDS virus?	—	—	—	<b>X</b>	<b>X</b>	—
c. Sharing needles for drug use with someone who has the AIDS virus?	<b>X</b>	—	—	—	—	—
d. Being coughed or sneezed on by someone who has the AIDS virus?	—	—	—	<b>X</b>	<b>X</b>	—
e. Getting a blood transfusion, that is, receiving blood donated by someone with the AIDS virus?*	<b>X</b>	—	—	—	—	—

\*In the 1992 NHIS, the question was worded "Getting a blood transfusion, that is, receiving blood donated by someone else." This change is intended to clarify whether the question was intended to tap knowledge that AIDS could be transmitted via blood, or that in the United States the blood supply is screened for the AIDS virus.

General AIDS knowledge was assessed using questions 3, 4a-c, and 4e-g. Knowledge of AIDS transmission methods was assessed using questions 4d and 5a-e.

## Broadcast and print media are the most promising ways of conveying information about AIDS, as they were the most commonly reported sources of information about AIDS.

Broadcast and print media appear to be the most promising ways of conveying information about AIDS, as they were the most commonly reported sources of information about AIDS among people surveyed, regardless of characteristics. Television was reported by 80 percent of subjects, radio was reported by 50 percent, and newspapers and magazines were used by 60 percent. Other resources such as health department workplaces or school brochures garnered only between 20 and 30 percent each, but may be effective at reaching specific subgroups. AIDS hotlines were reported by only about 2 percent of subjects and do not appear to be used by the public as a means of acquiring general information about the disease, although they provide a valuable resource for persons with specific questions about AIDS and HIV. Since knowledge levels increased with a greater number of sources from which the subject received AIDS information, a multipronged approach would be a good strat-

egy for educating the general population about the disease.

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P O W E R F U L P A R T N E R S H I P S

# COMMENTARY

## Selected medical malpractice cases in New Jersey

Neil E. Weisfeld

*God help us when doctors disagree.  
Chekhov, Uncle Vanya.*

Case reports. Occasionally, an individual may suffer from consecutive acts of negligence committed by more than one type of wrongdoer.

*The hole in the defendant's case.* To grab a beverage, a 39-year-old woman customer slid open the door of a self-service refrigerator in a bagel shop. Not positioned properly on track, the door fell from the unit, striking the customer on the bridge of the nose. She proceeded to a hospital emergency department.

After visiting the emergency department, the now ex-customer made an appointment with the otorhinolaryngologist (ear-nose-throat, or ENT, physician) who previously had performed two surgical procedures on her to correct sinus problems and had treated her for migraine headaches. The physician diagnosed a nasal fracture. Several months later, he performed a rhinoplasty to repair the fracture.

When facial pain persisted, the patient returned to the specialist, who now suspected damage to the temporomandibular joints (TMJ) in the jaw. The physician ordered MRIs, which were returned negative for both joints. He essayed conservative treatment, including injections of anesthesia, for four to six weeks. When the conservative course did not appear to succeed, the physician performed surgery on one of the joints. The pain intensified.

Referred next to a TMJ specialist, the patient eventually came under the care of an oral surgeon, who performed additional surgery. To treat the pain subsequently, steroids and anesthetic agents were administered by injection but failed to provide long-term relief. A TENS unit was implanted in the patient's abdomen. Referred ultimately to a pain specialist, the patient learned she would need large and potentially addictive dosages of pain medication.

Contending that the accident with the refrigerator door would not have happened in the absence of negligence by the bagel shop owner, the patient sued the owner. Given the duration and nature of the injury, however, the owner filed a cross-claim against the



ENT physician, alleging that the persistent and intense pain resulted primarily from unnecessary TMJ surgery. The patient then listed the physician directly as a defendant.

The case was tried in New Jersey. The customer/patient maintained that her presurgical pain was general to the face, not specific to the jaw. During the two years since the surgery, she testified, the pain in the jaw had worsened severely, and she had difficulty opening the side of her mouth that was affected. She described her constant, excruciating pain in the jaw and great difficulty in eating, talking, and laughing. These effects were expected to be permanent.

An expert maxillofacial surgeon testified on behalf of the plaintiff that, ordinarily, TMJ dysfunction occurs only in response to direct trauma to the jaw itself. And, the expert observed, trauma to the jaw was not mentioned in the emergency department record. The plaintiff's expert added that postsurgical MRI studies revealed significant damage, but that additional surgery was contraindicated. According to the expert, even the presence of TMJ dysfunction would not have justified the surgery that was done, because 90 percent of cases can be treated effectively without surgery. Conservative treatment should be attempted for one year before surgery, the expert contended.

In defense, the ENT physician related that in 1991, when the case first came to his attention, MRIs were not sufficiently reliable in showing the absence of TMJ damage, so that he could not accept the negative MRI find-

ings at face value. Clinical indications, the physician defendant explained, justified exploratory surgery, which in turn disclosed a microscopic fracture of the chondyle/disc component of the TMJ.

## COMMENTARY

The plaintiff emphasized that the ENT physician's operative report mentioned one year, not merely four to six weeks, of conservative treatment as well as a positive, not a negative, MRI. The physician asserted that the former discrepancy resulted from a typographical error. The latter error, he said, involved a delay in dictating the report, coupled with confusion between the MRI result and the intrasurgical finding of a fracture.

On cross-examination, the physician allowed that a postsurgical examination revealed that the patient would jump in severe pain when her jaw was touched. The jury found the bagel shop proprietor negligent in causing the original fracture and assessed this injury at \$2,000. No claim for lost wages had been made by the plaintiff. The jury further found the ENT physician negligent in causing the TMJ injury, which the jury assessed at \$1.5 million. In addition, the jury awarded the plaintiff's husband \$250,000 for loss of consortium.

Commentators noted that the negative MRI and the brevity of the conservative course of treatment, combined with errors in the written report, appeared to influence the jury and constitute the greatest holes in the physician defendant's case.

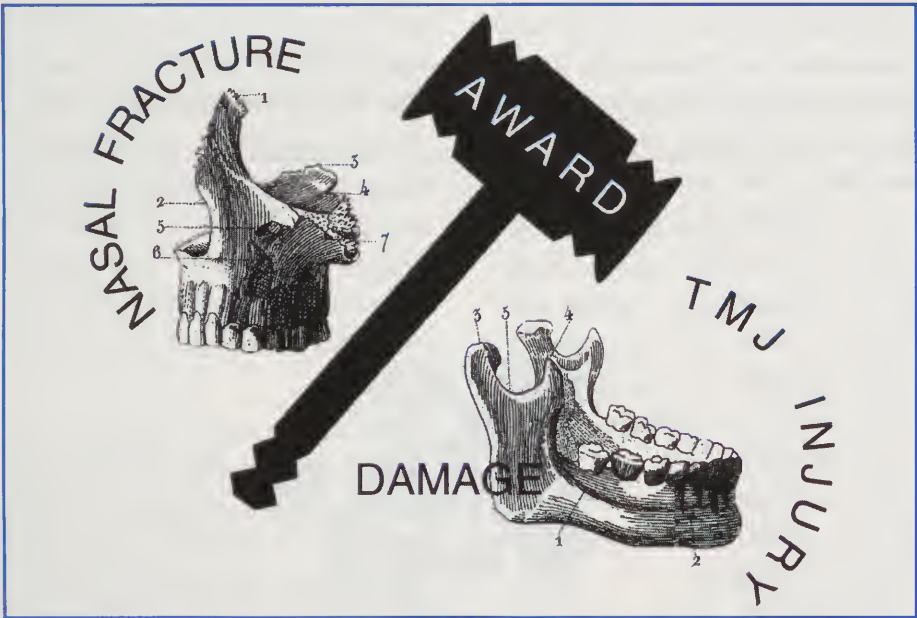
NJ

# COMMENTARY

*Morphine and cardiac arrest.* After suffering from a fever of unknown origin for several days, a 45-year-old man with a wife, three children, and an annual income of \$80,000, was admitted to a hospital. The patient developed severely increased respiration, which aggravated his anxiety. A

A malpractice case was brought in a New Jersey court, based on the theory that the resident and nurse were negligent in administering Ativan® in conjunction with morphine, especially in light of abnormalities detected in a liver function study. These abnormalities might have cast doubt on the body's ability to metabolize the medication.

An expert pharmacologist testified on behalf of the plaintiff that Ativan® is



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resident in family practice prescribed the sedative, Ativan®, with an advisement to the nurse to repeat the dosage one hour later if needed. The patient already was receiving morphine.

The second dose was administered, but the rate of respiration continued to climb. Two and one-half hours later, while an anesthesiologist was intubating the patient in preparation for placing him on a respirator, the patient went into cardiac arrest. A code was called, but the patient expired.

contraindicated with morphine, because the combination of drugs can interfere with respiration. The nurse, said the pharmacologist, should have questioned the order, which the resident never should have given.

Disputing the plaintiff's view of the chain of causation leading to the death, the defense argued that the patient's underlying condition made intubation necessary. During the course of intubation, the defense continued, a paralyzing drug, succinylcholine, was admin-

JM



istered. Although this administration was proper, said the defense, the patient experienced a recognized complication of the drug, which caused the cardiac arrest. Under the defense's theory, Ativan® did not cause the death—which is why the patient's respiration rose, rather than fell, after Ativan® was given. The jury found the defendants not negligent.

*Unnecessary prostate surgery?*  
Afflicted with an enlarged prostate, a 64-year-old male patient underwent a transurethral resection (TURP). A urinary stricture resulted, and a series of surgeries was commenced to dilate the urethra.

Contending that his original symptoms were not severe enough to justify the TURP, and that the urologist who performed the procedure had failed to obtain the patient's informed consent to the surgery, the patient brought a malpractice action in New Jersey against the urologist. The patient, however, did not allege that the surgery was performed negligently.

The patient claimed that the physician had told him that he had cancer, although in fact the patient's condition was benign. In addition, an expert urologist testified for the plaintiff that urinary stricture is a recognized risk of TURP, which the physician should have explained to the patient before surgery when obtaining the patient's consent to the procedure.

The defendant described the patient's significant presenting problems of urinary frequency. The defendant further described a conservative course of treatment that had been

attempted before surgery was recommended. The defendant denied, vigorously, that he had advised the patient of the presence of cancer. In this last regard, the physician pointed to his records, which contained no mention of malignancy.

An expert urologist testified for the defense that urinary stricture is a very rare, if known, complication of TURP, which does not require prior disclosure. The jury found for the defense.

*Care of a child with defects at birth.*  
Despite proper care prior to and during delivery, a baby boy was born with cerebral palsy, spastic quadriplegia, and mental retardation that would limit intellectual development to a four-year-old level.

The boy grew up. At age 10, he developed hydrocephalus, for which a medium-pressure shunt was implanted surgically to release fluid whenever a significant buildup occurred. At age 17, he was hospitalized for scoliosis. During the hospitalization, the shunt was discovered to be broken and in need of replacement.

A neurosurgeon replaced the implant with a low-pressure shunt. During the next several weeks, the patient lost the ability to speak in simple sentences. He became lethargic and lost his appetite. Bilateral subdural hematomas were found on a CT scan. The neurosurgeon recognized changes in the brain and saw that the brain had appeared to have "collapsed somewhat."

## COMMENTARY

## COMMENTARY

When difficulties in swallowing emerged, two successive operations were performed to reduce aspiration.

The surgery was not successful. A permanent tracheotomy was undertaken to assist in the suctioning of secretions, a capacity that the patient had lost.

A malpractice action was brought in New Jersey against the neurosurgeon and came to trial when the patient was 23. The plaintiff alleged that the physician erred either in failing to ascertain from the patient's records that a medium-pressure shunt was indicated or in taking a pressure test of the ventricles of the brain. The low-pressure shunt, claimed the plaintiff, directed an excessive volume of fluid to be discharged, causing a partial collapse of the brain that led in turn to a loss of the ability to swallow and severe difficulties in respiration.

On the plaintiff's behalf, an expert neurosurgeon testified that the defendant had not conducted pressure checks that would have revealed that a low-pressure shunt would cause a valve

to open at an excessive rate, causing over-drainage of the ventricles and resulting brain damage.

The plaintiff maintained that respirator and ventilator care would be required permanently, as would regular suctioning and a feeding tube. According to the patient's pediatric neurologist, round-the-clock nursing care, thus, would be needed. The patient's parents, who did not have health insurance, presented a claim for the value of the services that they performed gratuitously. A life-care planning expert testified on behalf of the plaintiff that the care would cost \$377,000 per year, and the plaintiff's expert economist estimated the lifetime cost at \$7.5 million over the 20 years of expected survival predicted by the pediatric neurologist.

The plaintiff also displayed a videotape to the jury that was made at a birthday

party prior to the surgery in question. The videotape revealed the patient blowing out candles, opening gifts with some difficulty, and appearing to enjoy himself. Testimony also was elicited to describe the patient's earlier enjoyment of music, especially rock standards. Then, a "day-in-the-life" tape was played to evince the procedures



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involved in administering feedings, cleaning ventilator tubes, and administering prophylactic antibiotics and other medications.

In defense, the neurosurgeon asserted that the choice of shunt was a permissible judgment, and that the type of shunt appropriate at age 10 was not necessarily appropriate at age 17. Finding for the plaintiff, the jury awarded \$272,300 for past pain and suffering, including disability and loss of enjoyment of life, and \$907,700 for future pain and suffering, plus \$400,000 for past medical expenses, \$5.5 million for future medical expenses, \$336,000 for past home health services performed by the parents, and \$584,000 for future home health expenses. The total tag was \$8 million.

**Why doctors settle.** "One should not assume," the newsletter *Loss Minimizer* admonishes readers, "that a settlement is an admission of negligence or liability." This warning flies in the face of the growing conventional wisdom that a physician's malpractice settlements are an indicator of the quality of care, or lack of it, that the physician supplies.

Reasons for settlement listed by the newsletter include: deficiencies in the physician's record, even when the deficiencies are not emblematic of an injury to the patient; a defendant physician's negative personality, which would render the physician an unsympathetic witness regardless of the quality of care provided; the availability of convincing expert witnesses for the plaintiff, even if the witnesses lack clinical experience in the relevant type of case; and economic factors, which

make settlements a preferred alternative to protracted litigation.

Settlements are becoming less popular among physician defendants, however, the newsletter goes on to relate. This is precisely because settlements are reportable to the National Practitioner Data Bank, hospitals, medical licensing boards, and managed care organizations. Medical boards and HMOs, in particular, may be reluctant to overlook settlements that consumer groups may find reflective of poor quality.

**Malpractice law and managed care.** A brief summary of trends in malpractice law related to the growth of managed care has been published by The Robert Wood Johnson Foundation of Princeton. The reader-friendly summary is contained in a brochure entitled, *"Perspectives: Malpractice Law Evolves Under Managed Care."*

Among other incipient trends, the brochure notes the re-emergence of the "reputable minority" defense. Physicians who base clinical decisions on cost as well as quality factors could find safety in their own growing numbers—even when most physicians discount cost when reaching clinical judgments.

Where would the patient be left, when some physicians consider cost and others do not—when physicians disagree not only on the standard of care but also on the criteria for identifying the standard? Surely, Uncle Vanya would despair. Mr. Weisfeld is deputy executive director, Medical Society of New Jersey.

## COMMENTARY

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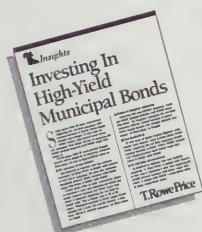
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## OPHTHALMOLOGISTS AND OPTOMETRISTS: WHO SHOULD USE A NEW LASER PROCEDURE?

*Donald J. Cinotti, MD*

*Health care planning should demand the best trained providers and the highest quality of care. Medical doctors make the difference.*

the laser was approved for patients with up to seven diopters of myopia. Since then, headlines in major national newspapers proclaimed the birth of a billion dollar market.

In the field of eye care, there has been an escalating "turf" battle between ophthalmologists and optometrists. It started with diagnostic drops, and in 1991 a law was passed allowing optometrists to diagnose and treat ocular diseases with topical medications.

Since the FDA approval, the Board of Optometry in Idaho declared the excimer laser within the scope of practice of optometry. In Oklahoma, the Board of Optometry previously had approved the YAG laser to be within its scope of practice. In both states, the boards of medicine joined with local ophthalmological societies and the American Academy of Ophthalmology to institute lawsuits. The argument is that lasers are surgical instruments and that the

In October 1995, the Food and Drug Administration (FDA) approved the use of the excimer laser in photo refractive keratectomy (PRK). This laser uses ultraviolet light to ablate the anterior surface of the cornea in the visual axis resulting in a change in the refractive power of the eye. Specifically,

practice of surgery is governed by the boards of medicine. The judicial system now will decide on the definition of surgery.

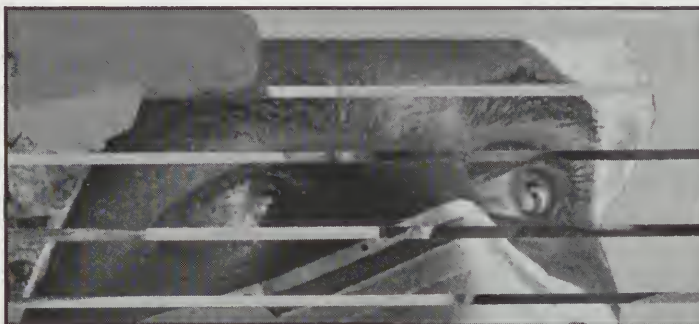
Optometry's arguments for the ability to use lasers are subtle; they declare that physicians would be surprised at how advanced optometry education has become. Although this may be true, medical education and ophthalmology training also has greatly expanded. The undergraduate curriculum still is four years, and there has been no expansion in the number of patients with pathology that optometry students examine. This is no comparison to an ophthalmologist with four years of medical school, one year of internship, three years of residency, and one or two years of fellowship in cornea. It is evident that the education and training of these two professions are not equivalent.

Next, optometrists claim that PRK is new technology and, therefore, fair game for all. There is no basis for this claim because ophthalmologists have been trained in surgery, and have used various lasers for many years. During residency, a great deal of experience is gained in the indications for surgery, pre- and postoperative care, and handling complications. We do not produce great surgeons or clinicians by reading textbooks or taking a few weekend courses. Ophthalmology residents learn surgery in a very deliberate fashion under the guidance of experienced professors on real patients. Optometrists are claiming this experience, being taught by other optometrists using mannequins.

The argument used by the boards of optometry is that the use of the laser is not surgery but a procedure. The excimer laser is a precision surgical instru-



ment and is very effective in the hands of a skilled surgeon. We should not be fooled into believing that these lasers are controlled completely by computers or that lasers do not alter or remove human tissue. Since optometry boards are attempting to approve all lasers, optometrists will claim the ability to treat diabetic retinopathy, secondary membranes, retinal holes or tears, and glaucoma with several different lasers. New lasers now are available for blepharoplasty, plastic surgical procedures, and dacryocystorhinostomy. These, along with any future developments including lasers to remove cataracts, also will be claimed to be within optometrists' scope of practice.



The advent of managed care has created a window of opportunity for many health care provider groups to expand their scope of practice and challenge the necessity for a medical degree. The "turf" battle is not only whether limited licensed practitioners can perform surgery, but is the time and effort necessary to produce a medical doctor or surgeon cost effective. There no longer are enough health care dollars for the amount of providers. Therefore, it is not a surprise that many groups are attempting to expand their reimbursement codes. The problem is to ensure that patient care remains at the same level of quality. We know that to attain maximum skill as a clinician or surgeon, a sufficient number of cases must be managed. For optometrists to gain this degree of skill, surgical cases must be taken away from ophthalmologists. So, instead of highly trained surgeons, we would have numerous half-trained individuals unable to maintain skills due to the dilution of their caseloads.

Finally, what does the patient want? Over the past several years, polls have been conducted to determine if the people in this country know the difference between an ophthalmologist and an optometrist. Clearly the majority are confused. In a recent Harris poll, 40 percent of the respondents believe optometrists attend medical school. However, when the differences between the two professions are explained, 95 percent of those polled preferred to have PRK performed by an ophthalmologist.

Health care planning should demand the best trained providers and the highest quality of care. Allowing optometrists to perform laser surgery does

not meet this goal. Medical doctors make the difference.

**NJM**

*Editor's note. A few months ago, Connecticut senators gave authorization for optometrists to use lasers, treat glaucoma, and prescribe oral drugs. Bills introduced in the New Jersey Legislature have died and have not been reintroduced. Yet, in the past two years, legislation to allow optometrists to use lasers has been submitted in Alaska, Colorado, California, and Virginia. In addition, optometrists in Idaho already are using lasers. The New Jersey Optometric Association declined at this time to comment on this issue. We welcome your opinion and your comments on this topic.*

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September 8, 1996  
Barnert Hospital, Paterson  
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### **Tuberculosis**

September 9, 1996  
UMDNJ, Newark  
201/982-4267

### **Dermatology Meeting**

September 10, 1996  
Schering Corporation, Kenilworth  
908/298-4000

### **Care of Persons with Huntington's Disease**

September 11, 1996  
St. Joseph's Hospital, Paterson  
201/977-2000

### **Management of Pediatric HIV**

September 11, 1996  
Somerset Medical Center, Somerville  
908/685-2200

### **Radiation Oncology Meeting**

September 11, 1996  
The Manor, West Orange  
201/731-2360

### **Restorative Nursing**

September 11-12, 1996  
Gov. Morris Hotel, Morristown  
201/539-7300

### **Advanced Gynecologic Surgery**

September 12-14, 1996  
The Hilton, New York  
212/586-7000

### **ZDV Therapy in Pregnancy To Reduce HIV Transmission**

September 13, 1996  
Memorial Hospital, Mount Holly  
609/267-0700

### **Anticoagulation Therapy**

September 16, 1996  
Woodbridge Developmental Center  
609/275-1911

### **Guidelines for Safe Clinical Use**

September 17, 1996  
Marriott, Somerset  
908/560-0500

### **Women's Wellness Seminar**

September 18, 1996  
UMDNJ, New Brunswick  
908/235-5600

### **Management of Pediatric HIV**

September 19, 1996  
St. Joseph's Hospital, Paterson  
201/977-2000

### **Vascular Society Meeting**

September 19, 1996  
Four Seasons Hotel, Philadelphia  
215/963-1500

### **Cardiovascular Disease**

September 19, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Cardiology Meeting**

September 20-21, 1996  
Nassau Inn, Princeton  
609/921-7500

### **Administration for Psychiatrists**

September 21, 1996  
Kessler Conference Center, West Orange  
609/561-6700

### **Women's Wellness Seminar**

September 25, 1996  
UMDNJ, New Brunswick  
908/235-5600

### **Domestic Violence Issues**

September 25, 1996  
DHS2, Trenton  
609/292-1212

### **Networking for Women**

September 26, 1996  
Holiday Inn, Princeton  
609/882-1048

### **Herbal Medicines in Nigeria**

September 26, 1996  
George F. Smith Library, Newark  
201/982-6293

### **MCMS**

### **Hall of Fame Dinner**

September 28, 1996  
Hyatt Regency, Princeton  
609/882-1048

### **Hysteroscopy Surgery**

September 28, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Hysterectomy Surgery**

September 28, 1996  
UMDNJ, New Brunswick  
908-235-5600

### **Anticoagulation Therapy**

October 1, 1996  
West Hudson Hospital, Kearny  
201/955-7000

### **Women's Wellness Seminar**

October 1, 1996  
UMDNJ, New Brunswick  
908/235-5600

### **Diagnosis and Treatment of AIDS**

October 2, 1996  
VA Medical Center, Lyons  
908/647-0180

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For more information, contact the Office of Continuing Medical Education at 215-762-8263.

### SEPTEMBER 1996

SEPTEMBER 4th

#### Hypertension Management in Renal Insufficiency

*Michael A. Moore, M.D.*

Clinical Assistant Professor of Medicine  
Bowman Gray School of Medicine, Director,  
Danville Urologic Clinic, Danville, VA

SEPTEMBER 11th

#### Diagnosis and Treatment of Cardiac Arrhythmias for the Practicing Physician

*Michael Cain, M.D.*

Lewin Professor of Medicine  
Director, Cardiovascular Diseases, Washington  
University School of Medicine, St. Louis, MO

*Steven P. Kutalek, M.D.*

Associate Professor of Medicine  
Director, Cardiac Electrophysiology, Allegheny  
University Hospitals, Center City

SEPTEMBER 18th

#### The Molecular Basis of the Acute Coronary Syndrome—Mechanisms of Plaque Rupture in Acute Coronary Events

*Peter Libby, M.D.*

Associate Professor of Medicine  
Harvard Medical School, Director, Vascular  
Medicine and Atherosclerosis Unit, Brigham and  
Women's Hospital, Boston, MA

SEPTEMBER 25th

#### Advances in Therapy of HIV: Mechanisms of Action of Newest Antiretroviral Therapy

*Paul Volberding, M.D.*

Professor of Medicine  
University of California at San Francisco, Chief,  
AIDS Activity Service, San Francisco General  
Hospital, San Francisco, CA

### OCTOBER 1996

OCTOBER 2nd (8:30 to 12 noon)

#### Mechanisms and Advances in Treatment of Congestive Heart Failure

*Eugene Braunwald, M.D.*

Hershey Professor of the Theory and Practice of  
Medicine, Harvard Medical School, Chairman,  
Department of Medicine, Brigham and Women's  
Hospital, Boston, MA

OCTOBER 9th

#### Advances in Pulmonary Medicine

*David M. Center, M.D.*

Division of Pulmonary Medicine, Boston University  
Medical Center, Boston, MA

OCTOBER 16th

#### Advances in Cardiovascular, Renal and Cerebrovascular Medicine with Adenosine

*Ami Iskandrian, M.D.*

Professor of Medicine  
Director, Nuclear Cardiology, Division of  
Cardiovascular Diseases, Allegheny University  
Hospitals, Center City

*Luiz Belardinelli, M.D.*

Professor of Medicine and Pharmacology  
Department of Medicine, University of Florida  
School of Medicine, Gainesville, FL

*Christopher Grange, M.D.*

Associate Professor of Medicine  
Duke University School of Medicine, Durham, NC

*Robert Mentzer, Jr., M.D.*

Professor and Chairman  
Cardiothoracic Surgery, Director, Cardiopulmonary  
Transplantation, University of Wisconsin Hospital  
and Clinic, Madison, WI

### OCTOBER 1996

OCTOBER 23rd

#### Disorders of the TSH Receptor

*Martin I. Surks, M.D.*

Professor of Medicine and Pathology  
Albert Einstein School of Medicine, Head, Division  
of Endocrinology and Metabolism, Montefiore  
Medical Center, Bronx, NY

OCTOBER 30th

#### Advances in Allergy/Immunology for the Practicing Physician

*David M. Lang, M.D.*

Assistant Professor of Medicine  
Chief, Division of Allergy/Immunology, Allegheny  
University Hospitals, Center City

### NOVEMBER 1996

NOVEMBER 6th

#### The Changing Face of Community-Acquired Pneumonias: The Impact of Pneumococcal Resistance

*Daniel N. Musher, M.D.*

Professor of Medicine, Microbiology and  
Immunology  
Baylor College of Medicine, Chief, Infectious  
Diseases, VA Medical Center, Houston, TX

NOVEMBER 13th

#### Advances in the Treatment of Asthma

*David M. Lang, M.D.*

Assistant Professor of Medicine  
Chief, Division of Allergy/Immunology, Allegheny  
University Hospitals, Center City

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

SEPTEMBER 11, 1996

#### Diagnosis and Treatment of Cardiac Arrhythmias in Office Practice

Course Director: Steven P. Kutalek, M.D.  
Visiting Professor: Michael Cain, M.D.  
Washington University School of Medicine

OCTOBER 9, 1996

#### Advances in Pulmonary Medicine Treatment of COPD

Course Director: Edward S. Schulman, M.D.  
Visiting Professor: David M. Center, M.D.  
Boston University Medical Center

OCTOBER 16, 1996

#### Advances in Cardiovascular, Renal and Cerebrovascular Medicine with Adenosine

Course Director: Ami Iskandrian, M.D.  
Visiting Professors: Luiz Belardinelli, M.D.,  
University of Florida School of Medicine  
Christopher Grange, M.D., Duke University  
School of Medicine  
Robert Mentzer, Jr., M.D., University of  
Wisconsin Hospital and Clinic

OCTOBER 30, 1996

#### Advances in Allergy/Immunology for the Practicing Physician

Course Director: David M. Lang, M.D.

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service,  
Director of Continuing Medical Education for the Department of Medicine

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of the American Osteopathic Association.



# calendar

## FALL '96

### **Health Professionals Conference**

October 2, 1996  
MSNJ, Lawrenceville  
609/896-1766

### **Marketing Services Today**

October 2, 1996  
Holiday Inn, Princeton  
609/452-2400

### **Anticoagulation Therapy for Prevention of Stroke**

October 3, 1996  
Newcomb Medical Center, Vineland  
609/691-9000

### **Overview of Ob/Gyn**

October 4-8, 1996  
The Hilton, New York  
212/586-7000

### **Perinatal Association Meeting**

October 4, 1996  
Holiday Inn, Princeton  
609/452-2400

### **Health & Fitness Expo**

October 5-6, 1996  
Fairleigh Dickinson University  
201/646-4379

### **Dermatology Meeting**

October 8, 1996  
Schering Corp, Kenilworth  
908/298-4000

### **Sports Medicine**

October 9, 1996  
MSNJ, Lawrenceville  
609/896-1766

### **AMA-ERF Celebrity Luncheon**

October 9, 1996  
Garden State Arts Center, Holmdel  
609/896-1766

### **Postprandial Hyperglycemia**

October 10, 1996  
Woodbridge Developmental Center  
609/275-1911

### **Spina Bifida Issues**

October 10, 1996  
Kessler Conference Center, West Orange  
609/561-6700

### **Critical Care Symposium**

October 10-11, 1996  
Holiday Inn, Princeton  
609/452-2400

### **Orthopaedics Symposium**

October 11-12, 1996  
Marriott, Somerset  
908/560-0500

### **Nephrology Society Meeting**

October 15, 1996  
Overlook Hospital, Summit  
908/522-2000

### **Management of Hepatitis C**

October 16, 1996  
Seattle, Washington  
609/275-1911

### **Anticoagulation Therapy**

October 16, 1996  
Warren Hospital, Phillipsburg  
908/859-6700

### **Postprandial Hyperglycemia**

October 16, 1996  
Union Hospital  
908/687-1900

### **Dermatology Conference**

October 17, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Radiological Society Meeting**

October 17, 1996  
Location to be announced  
609/275-1911

### **Mantoux TB Testing Course**

October 18, 1996  
UMDNJ, Newark  
201/982-4267

### **Physicians and the Media**

October 19, 1996  
American Society of Journalists  
212/997-0947

### **Plastic Surgery**

October 19, 1996  
Scheie Eye Inst., Philadelphia  
215/662-8100

### **Primary Care**

October 21-25, 1996  
Cooper Community Health Center  
800/826-6737

### **Management of Pediatric HIV**

October 22, 1996  
Newcomb Medical Center, Vineland  
609/691-9000

### **Medical History Society**

October 23, 1996  
Nassau Club, Princeton  
609/275-1911

### **Dermatology for Primary Care**

October 24, 1996  
RWJMS, New Brunswick  
908/235-7430

### **Visiting Professor Lecture**

October 24, 1996  
St. Barnabas Medical Center, Livingston  
201/533-5000

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Nov. 15-17, 1996 3rd Floor, St. James Room  
Dec. 13-15, 1996 45th St., 8th Ave., New York City

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In addition to holding 7-8 seminars & workshops per year, the International College of Acupuncture & Electro-Therapeutics organizes an Annual International Symposium every October and publishes *Acupuncture & Electro-Therapeutics Research*, *The International Journal* quarterly, through Cognizant Communications and is listed by 15 major international indexing periodicals (*Index Medicus*, *Current Content*, *Excerpta Medica*, etc.), is recognized as a major leading journal in the field. The most prestigious and internationally recognized, "Fellow of the International College" (F.I.C.A.E.) will be awarded to members of the College who present a minimum of 2 original research papers during the annual International Symposium and publish them in the official journal, or who have made significant contributions in the field.

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Pulmonary Complications in Collagen Vascular Diseases .....	Udaya B. S. Prakash, MD
Update on New Asthma Strategies for Office Practice .....	Warren R. Summer, MD
Current Therapeutic Options in Primary Lung Cancer .....	Udaya B. S. Prakash, MD
Pulmonary Thromboembolism: Diagnosis & Management .....	Warren R. Summer, MD
The Clara Falk Franks Lecture: Emerging New Infectious Diseases in Pulmonary Medicine .....	Dennis G. Maki, MD
Crisis in Antibiotic Resistance .....	Dennis G. Maki, MD
Evaluation of the Patient with Chronic Dyspnea .....	Donald A. Mahler, MD
The Spectrum of Suppurative Lung Disease .....	David M. F. Murphy, MD
Diffuse Lung Disease: A Guide for the Clinician .....	Mervyn Feierstein, MD

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# calendar

## FALL '96

### **Issues in Tuberculosis**

October 24, 1996

Kessler Conference Center, West Orange  
609/275-1911

### **Mammography Course**

October 25-27, 1996

Hyatt Regency, New Brunswick  
908/873-1234

### **Spasticity Management**

October 26, 1996

Kessler Conference Center, West Orange  
609/275-1911

### **Bioactive Lipids**

October 28, 1996

UMDNJ, Stratford  
609/566-6000

### **India Medical Systems**

October 31, 1996

George F. Smith Library, Newark  
201/982-6293

### **GI Disorders for Geriatrics**

November 1, 1996

RWJMS, New Brunswick  
908/235-7430

### **Enhancing Academic Excellence**

November 1, 1996

Kessler Conference Center, West Orange  
609/275-1911

### **Chronic Pain Management**

November 2, 1996

RWJMS, New Brunswick  
908/235-7430

### **Clinical Pharmacology of Eicosanoids**

November 4, 1996

UMDNJ, Stratford  
609/566-6000

### **Infection Control in the HIV Era**

November 6, 1996

Union Hospital  
908/687-1900

### **Integrating TB Management for HIV Infected Patient**

November 6, 1996

VA Medical Center, Lyons  
908/647-0180

### **Vascular Society Meeting**

November 6, 1996

The Manor, West Orange  
201/731-2360

### **Ob/Gyn Issues**

November 7-9, 1996

Disney Yacht & Beach Resort  
908/235-7430

### **Ob/Gyn Meeting**

November 8, 1996

Garden State Arts Center, Holmdel  
609/275-1911

### **Dermatology Meeting**

November 12, 1996

Location to be announced  
609/275-1911

### **Radiation Oncology Meeting**

November 13, 1996

The Manor, West Orange  
201/731-2360

### **Postprandial Hyperglycemia**

November 14, 1996

Newcomb Medical Center, Vineland  
609/691-9000

### **Domestic Violence Issues for Physicians**

November 14, 1996

Woodbridge Developmental Center  
609/275-1911

### **Domestic Violence Issues for Physicians**

November 15, 1996

Marlboro Psychiatric Hospital  
908/946-8100

### **Low Back: Management Techniques for Primary Care**

November 15-16, 1996

Kessler Conference Center, West Orange  
609/275-1911

### **Chronic Pain Management**

November 16, 1996

RWJMS, New Brunswick  
201/982-4267

### **Pathology Seminar**

November 16, 1996

UMDNJ, Piscataway  
908/235-5600

### **Trauma Continuum**

November 19, 1996

UMDNJ, New Brunswick  
908/235-5600

### **Nephrology**

### **Monthly Meeting**

November 19, 1996

Overlook Hospital, Summit  
908/522-2000

### **Anesthesiology Meeting**

November 19, 1996

Forsgate Country Club  
908/521-0070

### **Postprandial Hyperglycemia**

November 20, 1996

Warren Hospital, Phillipsburg  
908/859-6700

### **Wound Care Conference**

November 21, 1996

Kessler Conference Center, West Orange  
609/275-1911



# ALLEGHENY UNIVERSITY OF THE HEALTH SCIENCES

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## Cardiology Update

**Wednesday, 3-5 p.m.**

*This series is designed for the health care provider and offers an intensive survey of the current status of clinical cardiology, allowing application of new knowledge and technology to the diagnosis and treatment of patients.*

Program Directors: Bernard L. Segal, M.D., and Michael S. Feldman, M.D.

**October 2, 1996    Bedside Diagnosis of the Cardiac Patient - Part I**  
**Moderators: Bernard L. Segal, M.D.**  
**Michael S. Feldman, M.D.**

Patients will be presented with interesting clinical findings. Carotid and jugular venous pulsation will be analyzed. The precordium will be palpated to determine abnormal impulses. Heart sounds and murmurs will be interpreted in light of the patient's symptoms and the clinical findings. Appropriate patients will be presented including those with abnormal splitting of the second heart sound, opening snaps, third and fourth heart sounds, ejection clicks and mid-systolic clicks. Stethophones will be available at each seat so that the audience will be able to hear and interpret these findings. Appropriate echocardiograms will be shown.

### **Upcoming programs:**

November 6, 1996    —Clinical Electrocardiography  
December 4, 1996    —Reperfusion in Acute Myocardial Infarction

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## FALL '96

### **Radiology & Ultrasound Meeting**

November 21, 1996  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **New Targets in Stroke Research**

November 22, 1996  
UMDNJ, Stratford  
609/566-6000

### **Aspects of HIV/AIDS**

November 26, 1996  
Trenton Psychiatric Hospital  
609/633-1500

### **Study of Renaissance Medical Students**

November 21, 1996  
George F. Smith Library, Newark  
201/982-6293

### **Women's Health: The 21st Century**

November 22-23, 1996  
Holiday Inn, Atlantic City  
609/275-1911

### **Infection Control in the HIV Era**

December 2, 1996  
UMDNJ, Newark  
201/982-4267

## *Here's what we are covering in October 1996*

- ⇒ **What changes will Election '96 bring to the Garden State?**  
Political writer Dave Rebovich, from Rider University, analyzes the candidates and their platforms.
- ⇒ **What's new at the New Jersey HMO Association?**  
Bill Berlin interviews Paul Langevin, Jr, the president of the New Jersey HMO Association, for an update.
- ⇒ **Do you know the ins and outs of selling a medical practice?**  
Attorney Michael P. Weiner from Stark & Stark presents a step-by-step approach to selling a medical practice.
- ⇒ **What changes are taking place at New Brunswick's Robert Wood Johnson University Hospital?**  
President Harvey Holzberg details his vision for the academic medical center and its future plans.
- ⇒ **Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.**

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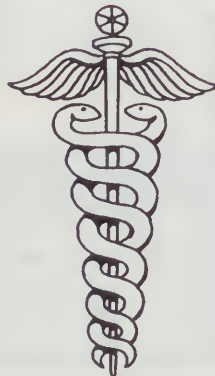
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Stephanie Frey, Principal

(continued from page 80)

## MSNJ Alliance appointments

Dorothy Espinola, MSNJ Alliance past-president, was reappointed to serve a second term on the AMA Alliance Health Promotions Committee and was elected to serve on the AMA Alliance National Nominating Committee. Christine Kline, immediate past-president of the MSNJ Alliance, was appointed to serve on the AMA Alliance Membership Committee.



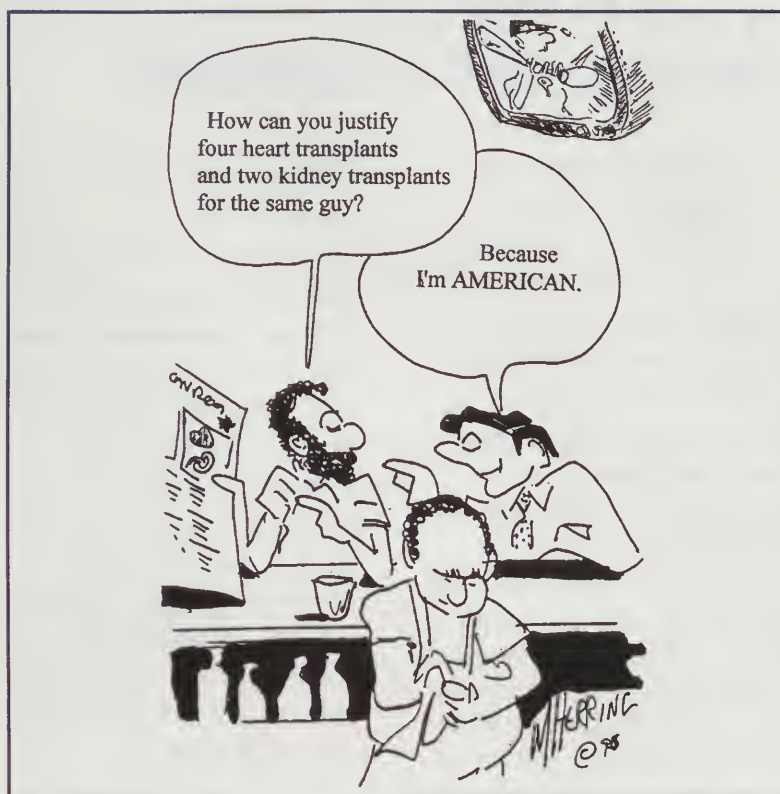
Dorothy Espinola and Chris Kline

## A New Jersey legacy retires

Jacob Churg, MD, retired after 50 years as an eminent pathologist. He was honored at ceremonies for his lifelong dedication to the field of pathology and to his patients. Dr. Churg has a national and international reputation in the fields of asbetosis and renal diseases. He has been affiliated with Barnert Hospital since 1946, serving as chief pathologist; director of laboratories; and president of the medical staff. He is a consultant to several northern New Jersey hospitals and to the National Institutes of Health.



Jacob Churg, MD



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine.

## Sports seminar

Sports Medicine '96, will furnish state-of-the-art information about caring for today's athletes. The program will be held on October 9, 1996, at MSNJ executive offices, in Lawrenceville. The program is cosponsored by The Academy of Medicine of New Jersey and MSNJ's Committee on Medical Aspects of Sports. For information on this day-long seminar, call MSNJ, 609/896-1766.

## Who should fund medical research?

The AMA House of Delegates agreed that scientific journals should decline tobacco-funded research. Joseph W. Sokolowski, Jr, MD, delegate to the AMA from the American Thoracic Society, which introduced the proposed resolution, was quoted as saying, "We are asking the AMA to continue its position as an advocate against the tobacco industry—to maintain its position on the moral high ground." Dr. Sokolowski is a member of MSNJ.

## Person of the year

New Jersey *MEDICINE* announces its competition for the 1996 Person of the Year. This recognition acknowledges a prominent newsmaker who effected change in the health care community in the Garden State. We are accepting nominations until October 1, 1996. Please send a 100-word statement explaining why this person should be selected to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648, FAX: 609/896-1368.

**NJM**



## A DAY IN THE LIFE: MEDICAL MINI-INTERNSHIPS

Mini-internships offer physicians and other health care professionals a rare and valuable opportunity to interact with influential decision makers in the state. A mini-internship expands the participants' perspectives on health care.

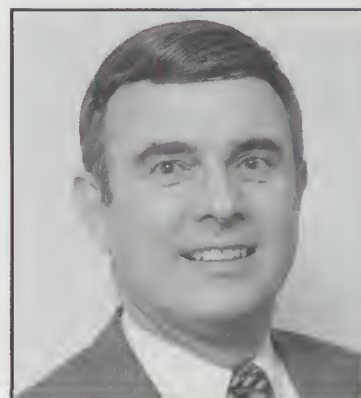
Under the direction of Carol Simpson, Atlantic County Medical Society recently completed a two-day mini-internship and the reviews are excellent. Interns spent time with physicians, accompanying them on hospital rounds, office visits, and surgical procedures. In addition, participants questioned health care professionals and discussed concerns about the practice of medical care throughout the day. One of the interns noted, "Shadowing Drs. Baker, Constantini, and De Meo over the two-day period not only enhanced my knowledge about patient care and treatment, but sensitized me to the demanding expectations, risks, and challenges doctors face."

Simpson added, "The goal of a mini-internship is to awaken interns to the very real human concerns of medicine that often are unseen and unappreciated. And the real benefits of the program come from the interns reaction to the good physician-patient relationship that exists and flourishes in spite of the drawbacks imposed from outside that relationship."

### Names in the news

Joan Sorenson, MD; Christopher M. Papa, MD; John Slade, MD; Richard M. Hodosh, MD; and Caterina A. Gregori, MD, are just a few of the many MSNJ physicians selected to be listed in *The Best Doctors in America*®: Northeast Region, 1996-1997. This new regional guide is intended to recognize doctors in communities throughout the Northeast area with superior clinical abilities that may or may not have drawn national attention.

St. Joseph's Hospital and Medical Center, in Paterson, announced the appointment of J. Reid Sterrett, MD, as chief of nephrology; he is a member of MSNJ and its Morris County component, and is certified by the American Board of Nephrology, the American Board of Internal Medicine, and the



J. Reid Sterrett, MD

National Board of Medical Examiners.

Edward A. Schauer, MD, has been elected vice-president of the Organization of State Medical Association Presidents (OSMAP). Dr. Schauer is a family practitioner affiliated with Jersey Shore Medical Center, in Neptune; a delegate to the MSNJ House of Delegates; a member of the Monmouth County Medical Society; and a fellow of the American Academy of Family Practice.

### Kudos to New Jersey MEDICINE



Recently transitioned to a health policy and health care news feature magazine, *New Jersey MEDICINE* received an honorable mention in the American Association of Medical Society Executives (AAMSE) 5th annual Pinnacle of Success Awards. The magazine competed in the "socioeconomic or news/feature periodical publications" category. A certificate was presented to *New Jersey*

*MEDICINE* at the AAMSE Annual Conference in Pittsburgh. "The Medical Society of New Jersey is extremely proud of this recognition and honored by this tribute to success," said Howard D. Slobodien, MD, editor-in-chief of *New Jersey MEDICINE*.

(continued on page 79)

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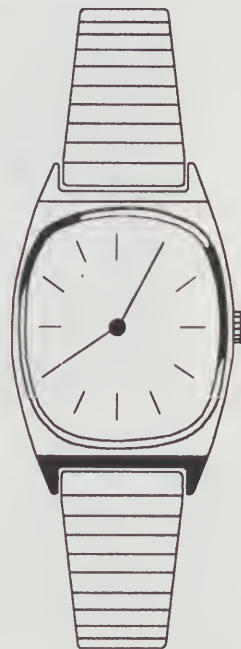
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*Health Care in the Garden State*

October 1996

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**PAUL LANGEVIN  
ON HMOs**

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## newsWATCH

The Garden State garnered seven honorable mentions in 11 categories of controls on HMOs in an "Older Americans Report" issued by advocacy group Families USA. The New Jersey controls appear in regulations that still are pending, as state officials navigate through some 600 comments filed after the regulations were formally proposed on May 20.

**New York** led the pack in the Families USA citations, receiving "best consumer protections" listings in seven areas. **California** also did well.

Another publication, the new quarterly *Cost and Quality*, places New Jersey squarely in Stage 3, "Consolidation," within the five stages of man . . . aged care. Writer **Russell C. Coile, Jr.**, exhorts states to skip the "brutal market warfare" of Stage 4 and move directly to Stage 5, in which "payers and providers are ready to shift to cooperation instead of competition." (Don't count on it.)

**Noted University of Pennsylvania health economist Mark V. Pauly** says Medicare reform could surprise us by impeding HMO penetration among the elderly. **Reductions in fee-for-service (FFS) payment levels, projects Dean Pauly, would result in equivalent out-of-pocket premium costs for beneficiaries, regardless of whether they choose an HMO or "classic" FFS coverage.**

But, greater local acceptance of HMOs by all residents will spur HMO enrollments into Medicare, rejoins **Congres-**

**sional Budget Office** analyst **W. Pete Welch**. Appearing alongside the Pauly piece in the fall issue of the revamped *Health Affairs*, the Welch work notes, though, that Medicare HMOs are most competitive in areas with high FFS payment rates. Prospects for continued high rates are dim. As **Physician Payment Review Commission** Chair **Gail Wilensky** has insisted, cutbacks are needed to reduce annual growth below 4.3 percent, despite an aging population, unless Medicare is to lose solvency within ten years.

The *Health Affairs* issue also contains the widely noted report that physician income declined an inflation-adjusted average 4 percent in 1994, the first such drop ever observed. Using **American Medical Association (AMA)** data, **Carol J. Simon** and **Patricia H. Born** found that losses were concentrated among the highest earning physicians, among specialties that enjoyed the highest growth during the late 1980s, and in geographic areas where managed care moved from moderate to full-blown penetration.

The shift toward primary care was only slightly in evidence. Although **family physicians** saw a 2 percent gain, their income remained relatively low, while **general internists** and **pediatricians** experienced substantial losses. Consider this implication: In the brave new world of managed care, physicians across the board are expected to become more caring, conscientious, and communicative, while facing unprecedented financial uncertainties and disruptions.

Hospital costs, too, declined in 1994, declares still another team of *Health Affairs* authors, led by **Prospective Payment Assessment Commission**



Deputy Director **Stuart Guterman**. As a result, the Medicare payment-to-cost ratio rose to 97 percent.

Opportunities are being offered to mid-career health professionals through the Kellogg National Leadership Program (800/474-1800, applications due December 2, 1996) and The Robert Wood Johnson Health Policy Fellowships (202/334-1506, applications due November 15, 1996).

**The AMA's Office of General Counsel sounds thrilled with the new hard-won antitrust enforcement guidelines jointly issued August 28 by the Federal Trade Commission and Department of Justice. To escape being found in per se violation of the antitrust laws, network physicians now don't have to share risk through capitation or fee withholds—ventures that require large capital and may require insurance licenses—so long as the network is integrated through utilization review (UR), careful selection of physicians, and an investment in infrastructure.**

Moreover, FFS networks engaged in direct contracting can escape antitrust scrutiny by rewarding member physicians when utilization goals are met and penalizing physicians when the goals are not won. (The AMA hopes that rewards themselves will be sufficient.) Networks applying UR or similar controls across-the-board are free to negotiate both capitation and FFS arrangements with a payer.

Even unintegrated networks may be permissible, if a relaxed "messenger model" is used to set fees. The messenger receives an acceptable fee range from

each physician, compiles this information across the entire network, presents the information to the payer, and communicates the payer's resulting offer back to the physicians.

Retained in the guidelines are the "safety zone" requirements that exclusive networks include no more than 20 percent of physicians in a geographic market, and that nonexclusive networks include no more than 30 percent. But, the guidelines contain an assurance that networks outside the safety zone, especially nonexclusive networks, still are likely to pass muster. In particular, networks in which different categories of physicians have different incentives will be viewed as benign.

Previously the agencies had been severely criticized by numerous observers, including prominent antitrust law advocate **Clark C. Havighurst**, for excessive zeal against physician groups. A less restrictive approach has been a top AMA legislative and regulatory priority.

**Is insider trading a health problem? The prestigious *New England Journal of Medicine* shared an advance copy of a press release—summarizing an editorial supporting use of a new drug—with authors of an accompanying article who also were paid consultants to the drug manufacturer. Result? A 13 percent prepublication rise in stock.**

And, on the left coast, FHP International Corp. enjoyed a 26 percent boost in three days before being acquired by PacifiCare Health Systems, Inc. "A man hears what he wants to hear and disregards the rest."—Paul Simon, *The Boxer*.

**Neil E. Weisfeld**



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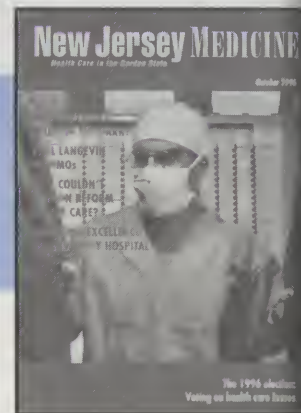
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New Jerseyans are very concerned about health care and reform is just a matter of time. Author David P. Rebovich, PhD examines the '96 presidential candidates and their stand on health care reform and its impact in the Garden State.

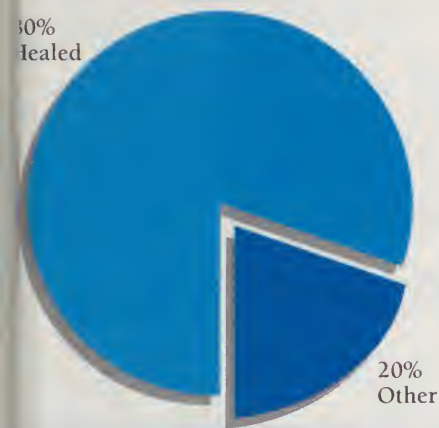
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# New Jersey MEDICINE

## *Medical science and policy*

MSNJ policies ought to be based on sound fundamental principles and incontrovertible data, yet flexible enough to undergo revision without sacrificing credibility. Moreover, these policies need to be clearly expressed.

The recently approved official policy statement on HIV/AIDS, developed by the Committee on AIDS and the Council on Public Health, and endorsed by the Board of Trustees, is a welcome addition to MSNJ's *Policy Compendium*, highly focused and pertinent to the needs of MSNJ's membership and the public.

However, this policy contains certain vague references, e.g. regarding mandatory testing—what is meant by scientifically inappropriate?, and controversial recommendations, e.g. support of needle exchange programs, that tend to undermine credibility and weaken the overall impact of the document.

Mandatory testing for HIV infection is clearly indicated in screening the blood supply but may not be scientifically valid to promote early detection, facilitate timely treatment, or reduce transmission. The latter are social issues, subject to debate and interpretation, but should not be regarded as inappropriate concerns.

While some data exist to justify the existence of needle exchange programs, the data are controversial and subject to revision pending further experience and study. In addition, some individuals feel that permitting needle purchase without a prescription is illogical, inconsistent, and counter-productive, regardless of the seemingly beneficial effect.

Because AIDS and HIV testing are highly charged issues, with important social and political ramifications, the development of acceptable, relevant, and utilitarian policies can be a difficult and convoluted process. Nevertheless, physicians look to MSNJ for guidance and support and they are entitled to clarity and reasonableness in policy development.

*Alan J. Lippman, MD*

## *Young physicians—a few words*

Is there timely advice we can deliver to the young physician? Indeed there is.

We hear young colleagues in the doctors' lounge planning to form small groups. They overlook one wisdom of hindsight—put your name on the group. What if the Mayo brothers or Dr. Frank H. Lahey had not put their names on their practices? If several doctors are starting together, add the word, associates. This word makes it clear that other

doctors might be added. Think of all the people in your hometown who will know your name. Build your name while you build your practice!

After 34 years of successful practice, I realize that it was an oversight not to leave behind "The Soled Associates Medical Clinic for Geriatrics." Other physicians reading this will nod heads in nostalgic agreement.

Young physicians should read books on management and self-improvement. When you analyze how corporations grow, fail, strive for quality, seek new markets, generate enthusiasm among employees, and plan for employee retirements, then the world suddenly is seen as a small replica of the giants. These problems are the same for individual physicians.

One book, *Built To Last*, by James C. Collins and Jerry I. Porras, details the success of visionary companies. The authors studied and compared 30 companies and how the chief executive officer preserved the core values of the company. Substitute the word "practice" for "company" and you can note the resemblance.

Another book, *The Leadership Challenge* by James M. Kouzes and Barry Z. Posner reviews the "nitty-gritty" of management, and will keep the reader thinking of a hospital committee chair, "I wish



someone would give this book to so-and-so."

Managed care has forced physicians to change how they look at a medical practice. There are agencies that can help a physician run the office efficiently, but it all begins with improving yourself. The physician in search of a generation of excellence plans the beginning in front of the mirror.

*Morris Soled, MD*

## *Tenure debate*

*The following edited letter was written to Dr. Arnold Rosenheck, chair of the UMDNJ Board of Trustees.*

I am writing to express my concern previously discussed with you in June about the suspension of a UMDNJ physician for two weeks without pay. As I recall, my exact words were, "How can such a suspension be justified in light of the bylaws and procedures of UMDNJ?" Your response was, "The suspension cannot be justified." You went on with a discussion that the suspension was an effort to send a message to the entire UMDNJ faculty that you, the president, and the administration of UMDNJ were going to do away with tenure. As I recall, you were verbal and opinionated regarding the need to do away with tenure and you even compared it to recertification by specialty boards for practitioners.

Such devious underhanded attacks on individual doctors

and faculty members cause an enormous human cost for those who are your victims. Who are you or any trustee or any administrator to make such nefarious judgments in contravention to bylaws and contracts? No one elected you or anyone else. Who voted for you? Each of you are appointments subject to the vagaries and vicissitudes of the political process. What academic, professional, ethical, or moral credentials allow any of you to arrogate to yourselves such enormous malevolence? Power corrupts and this is a terrific example of an abuse. Individuals pay the price for the arrogance of power.

In your discussions about incompetent health care professionals, we could agree that such individuals should be dismissed. For example, in our specialty an oral and maxillofacial surgeon (OMS) who treats late stage oral cancer with vitamins should be dismissed for cause. Tenured faculty of such level of incompetence can be dismissed under current regulations but he has not been dismissed.

The appropriate ethical process would be to file charges for dismissal on the basis of professional incompetence. The mechanism to achieve this exists but your system has chosen not to use it.

UMDNJ did not even try to apply the dismissal mechanisms available to it, in cases such as the OMS example, because your main goal is not

to remove incompetent doctors. Your primary objective is to get the power to fire anyone you choose. Once you eliminate tenure, you will be free to "select" anyone who dares to challenge Stanley Bergen and his clones.

Tenure exists to protect capable professionals who voice unpopular opinions or take actions that conflict with the administration. Tenure exists to protect faculty from Board members and administrators who would support an illegal and unjustified suspension of a physician in your attempt to send a political message to those who you perceive as your adversaries.

The policy you have introduced of suspending health care professionals on the whim of an administrator without appropriate hearings and attention to bylaws and details, mirrors the managed care model that is devastating the health care profession. A physician who advocated alternative or more expensive treatment than the administrators or the "bean counters" want can be summarily dismissed.

It is a serious discredit to your well-known sense of personal integrity that you support policies that totally disregard due process, bylaws, contracts, and agreements that form the fundamental basis of a complex organizational structure.

Your response is expected.

*Herbert B.  
Dolinsky, DDS*

NJM



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## Neonatologist honored

The Center for Home Health Development presented **Shyan C. Sun, MD**, with the Annual Research Physician of the Year Award. Dr. Sun is credited with developing the first helicopter air transport team devoted to airlifting critically ill newborns and infants. Currently, Dr. Sun is director of neonatology at Saint Barnabas Medical Center, in Livingston and is a professor of clinical pediatrics at UMDNJ-New Jersey Medical School, in Newark.



Shyan Sun, MD

## Nurse appointments

Atlantic City Medical Center appointed **Pamela Hans, RN**, director of critical care and **Janet Daly, RN**, as patient care manager. Ms. Hans will have responsibilities at the city division in the Medical Intensive Care Unit, Trauma Intensive Care Unit, and the Critical Care Unit and at the mainland division in the Intensive Care Unit. Ms. Daly will be responsible for the Medical Intensive Care Unit and the Cardiac Care Unit at the city division.



Pamela Hans, RN

## Campaigning in cyberspace

In November, Americans will decide who leads the nation into the second millennium, who will control the United States House and Senate, as well as who will take command of a changing New Jersey. The election provides a visible means of voicing opinions on the leadership of the Garden State and of the country.

Candidates have taken to the information superhighway to attract votes. There are more than 4,000 sites available on politics and government and cover every political affiliation. To increase your political IQ using your computer, we offer a sampling of some world wide web



sites—**<http://www.voter96.cqalert.com>**: a launching point to unlimited political sites; **<http://www.dole96.com>**: Dole campaign site or **<http://www.CG96.org>**: Clinton campaign site; **<http://www.democrats.org>**: the National Democratic Party site; **<http://www.rnc.org>**: the Republican National Committee's site; and **<http://www.reformparty.org>**: Ross Perot's National Reform Party site.

Election day is **November 5, 1996**. Exercise your right to vote. It is your privilege and your responsibility.

## Resources available for health professionals

The Department of Defense has a toll-free telephone number **(1/800-472-6719)** for health care professionals to report medical information about the causes of health problems suffered by veterans of the Persian Gulf War. Also accessible is GulfLINK, a web site devoted to Gulf War issues (<http://www.dtic.dla.mil/gulfink/>).

The MSNJ Committee on Biomedical Ethics developed **Futile Care Guidelines**. The guidelines define medically futile therapy and offer a set of guidelines and processes for dealing with medically futile therapy.

The Health Research and Educational Trust of New Jersey (HRET), the nonprofit research and education affiliate of the New Jersey Hospital Associ-

ation (NJHA), published the first Spanish edition of the book, **A Woman's RESOURCE Guide to Breast Cancer Services in New Jersey**, mammography service providers in the Garden State. For more information, contact Penny Bolla, at NJHA, 609/275-4157. NJHA's web site address is <http://www.njha.com>.

*continued on page 14*

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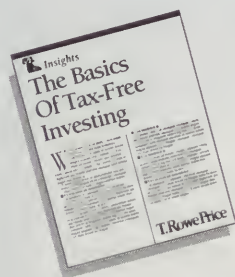
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†Past performance cannot guarantee future results. Read the prospectus carefully before investing. T. Rowe Price Investment Services, Inc., Distributor.

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continued from page 12

## Making news in the Garden State

The Academy of Medicine of New Jersey appointed **Jack T. Murray** as program manager for the Physicians AIDS Education Program. The Program offers free continuing medical education through Roving Symposia™ and publishes a newsletter.



Jack Murray

The former New Jersey commissioner of health, **Molly Joel Coye, MD**, joined HealthDesk Corporation, in Berkeley, California, as executive vice-president for strategic

development. HealthDesk is a developer of online systems for health information and disease management.

**Charles A.J. DeBerardinis, DO**, has joined the Department of Cardiovascular Diseases at Deborah Heart and Lung Center, in Browns Mills. His specialty is interventional cardiology.

**Firoozeh Vali, PhD**, has been named the director of research at the Health Research and Educational Trust of New Jersey (HRET), a nonprofit affiliate of the New Jersey Hospital Association.

**Howard M. Levine, DO**, has been elected president-elect of the American Osteo-

pathic Association. Dr. Levine is a family practitioner with a practice in Bayonne.

**Peter D. Corda, DO**, has been named medical director, Kennedy Surgical Center, in Washington Township.

**Nancy Carman, MA**, has been appointed corporate manager of ElderCare Services for Kennedy Health System, in Stratford.

The **Medical History Society of New Jersey** will hold its quarterly meeting on October 23, 1996, at The Nassau Club of Princeton. For information, contact Linda Bartolo at the Medical History Society of New Jersey, at 609/275-1911.

## Understanding the issue of domestic violence

The Academy of Medicine (AMNJ) and the Medical Society of New Jersey (MSNJ) will present a series of roving symposia on domestic violence. The series is designated for at least one hour of category 1 credit of the Physician's Recognition Award of the AMA. The curriculum was selected by a planning committee chaired by MSNJ member Ellen M.



Cosgrove, MD, director of CME, Monmouth Medical Center. To support this program, AMNJ was the recipient of an educational grant from The Robert Wood Johnson Foundation, in Princeton. For more information on these programs, contact Mae Slabicki, AMNJ associate director of research and education, 609/275-1911.

## Nurse attends conference in China



Sharon Gable, RN

**Sharon Gable, RN**, attended an international health care conference in China: the Citizen Ambassador Program of People to People International. The organization provides professional and cultural exchange opportunities; President Bill Clinton is the honorary chair. Ms. Gable is the manager of continuous quality improvement at Memorial Hospital of Burlington County, in Mount Holly.

## Siao joins RWJ at Hamilton



Peter Siao, MD

Robert Wood Johnson University Hospital at Hamilton welcomed **Peter Siao, MD**, to its medical staff. Dr. Siao is with the Department of Medicine, Section of Neurology. He also maintains a private practice in Lawrenceville. Previously, Dr. Siao was director of the electromyography laboratory and assistant professor in neurology at Allegheny University, Philadelphia.

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## Every country's health system is in crisis

"Ninety-five percent of human illness is self-limiting," said one of my medical school professors. That is fortunate for the patient, but also for the managed care companies, because denial of care usually results in no permanent harm to the deprived one. It also has been shown that patient satisfaction and quality of care do not parallel each other and that practice parameters and outcome studies still are in early developmental stages.

The delivery of health care by whatever system is supposed to assure access, universality, portability, and choice. The Health Insurance Portability and Accountability Act, signed by President Clinton this August, does not guarantee any of these qualities. Only some of the employed are guaranteed access and portability; none has all four, and all of the non-workers and some of the workers have no rights at all under the law.

A long-awaited Canadian trip this summer gave me the opportunity to examine, first-hand, our northern neighbor's single-payer program, the Canada Health Act. These are my impressions, recorded during the long Labor Day holiday, formed from personal interviews in Quebec and Ontario and from newspaper and television reports.

At the Canadian Medical Association (CMA) annual general council, the Ontario

Medical Association was asking for a controversial two-tiered system, one with core services paid from public funds, and the other for everything else, paid out of personal pockets, and designed to help compensate for the millions of dollars cut from health care funding. The reaction was swift. Federal Health Minister David Dingwall, perhaps

buoyed by a recent poll showing 75 percent of Canadians apprehensive of a two-tiered system, immediately quashed the notion, saying a majority of the people were happy with the present arrangements, although "improvements are always possible and reform is certainly needed." [My own personal interviews confirmed the general satisfaction of the Canadian people.] Recognizing the futility of the initial proposal, the CMA delegates voted 95 to 90 to "lead national discussions and debates on the appropriate place of regulated private insurance for medical services."

It may be instructive to reflect on the older doctors' approval of two-tier and the reticence of the younger ones. The CMA also will prepare a "charter of rights" for physicians and will be actively involved in the next election to "force the government to increase health spending."

There is no doubt in anyone's mind that the Canadian single-payer program has many



Howard D. Slobodien, MD

*For the sake of stimulating discussion, let me propose one version of a national, not necessarily federal, single-payer plan.*



# EDITOR'S

## D E S K

*Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.*

Susan Sontag, *Illness as Metaphor*, 1978.

*Great Socialist statesmen aren't made; they're stillborn.*

Saki (H.H. Munro), *The Unbearable Bassington*, Ch. 13, 1912.

problems. Money is tight. There are many delays in treatment and many patients come to the United States for needed care. The elderly now must pay a small part of prescription costs, previously a free benefit. Homeowners have extra burdens; in Montreal they had better remove ragweed plants and the like from their properties to avoid costs of treating allergy sufferers or suffer the cost of municipal removal and court fines. Physicians are emigrating. Eight hundred Winnipeg nurses may lose their jobs.

Americans should not be expected to adapt to unmodified health care delivery systems long commonplace in Western Europe and in the Commonwealth. We are cut from a different cloth; we tend to be individualistic and to resent governmental intrusion, unlike those in the Motherland and in the Fatherland, cousins under the skin. Physicians in the United States certainly fit the pattern; many of us entered the profession to take charge of our lives, as well as to improve the lives of our patients. We, therefore, have tended to be (ultra)conservative regarding governmental controls and have resisted all attempts to impose socialized medicine.

Times have changed. Managed care companies have imposed restrictions on medical practice and the payment for same more than we could imagine only a few years ago. Today, the major federal single-payer program, Medicare, is the easiest and most agreeable insured program.

It probably is whistling in the wind for me to suggest that we could promote a national single-payer system that would insure the

access, universality, portability, and choice that all Americans desire. The insurance companies would fight it tooth and nail; they and their stockholders have too many billions of dollars at stake. And a fair number of physicians would rather go down with the ship.

For the sake of stimulating discussion, let me propose, in extremely simplified form, one version of a national, not necessarily federal, single-payer plan. The federal government is a wonderful collector; through the IRS or other agency, it can collect a broad-based tax, probably based on income. We all would be covered for basic and necessary care. The distribution of monies and determination of payments would be made by an independent, nongovernmental board or commission, which would include significant representation from those groups that give care. Supplemental coverage would be available through insurance companies in a variety of ways, to include medical savings accounts. The national commission would establish regional groups and satellite agencies to create flexible standards of care, evaluate outcomes and patient satisfaction, and monitor the economics of care. Physicians and their societies, by necessity, would have significant input at all levels. The program also would help to solve the graduate medical education problem, noted in the August issue of *NJM*.

Back to reality. When you read this, the presidential and congressional elections will be on the horizon. Can anybody predict what type of health care and delivery Washington will let us have in the next one or two years? But I can dream, can't I?

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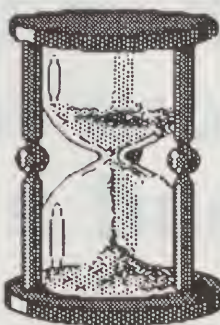
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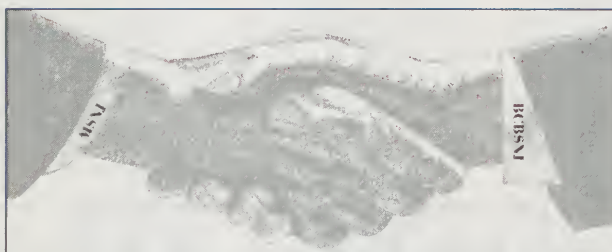
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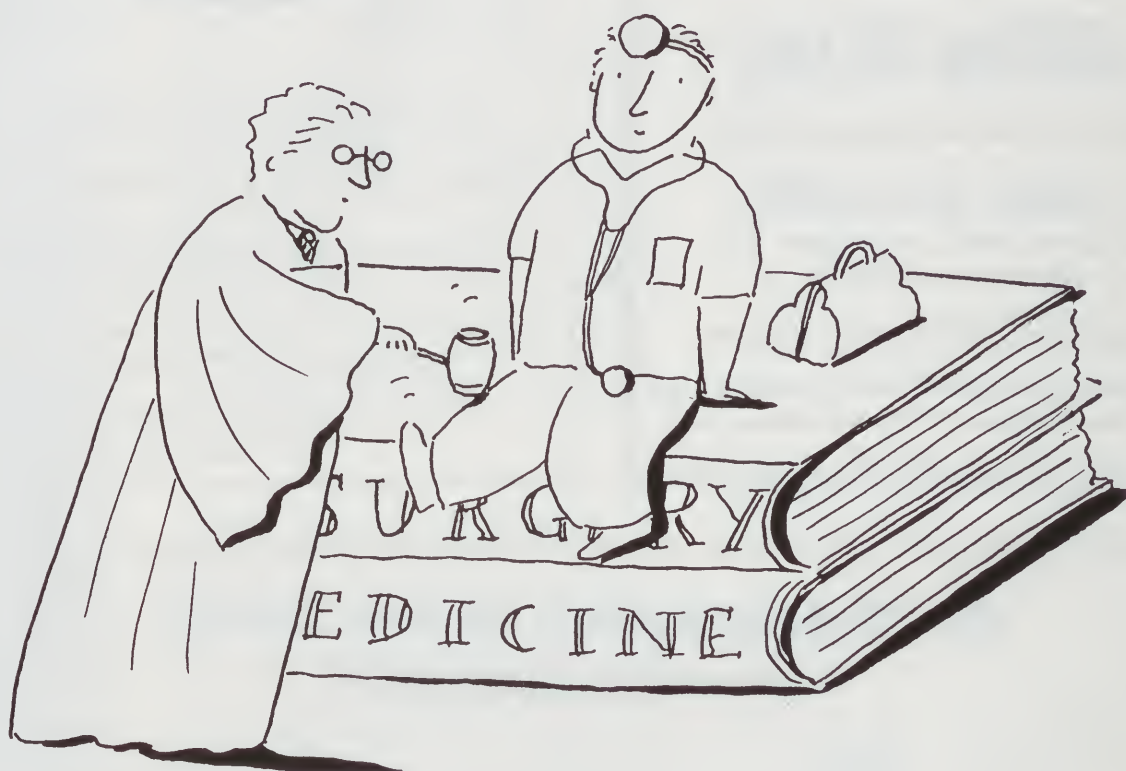
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## INTERVIEW WITH PAUL R. LANGEVIN, JR

**Mr. Langevin is president of the HMO Association, Inc. He also is a member of the Review Board for New Jersey MEDICINE.**

**Q.** Tell me about the HMO Association in terms of who you represent and what you do.

**A.** We represent the 10 largest HMOs in the state, out of 26 approved HMOs in New Jersey. Any authorized HMO is eligible to join. Most of them are nationally recognized companies, some doing just HMO business, others doing HMO and indemnity and everything in between. We have about 92 percent of the market share for the commercial and government market in New Jersey. We do lobbying, public relations, and research for the 10 HMOs and for the industry at large.

**Q.** What do you see as the major trends in terms of managed care in this state?

**A.** Clearly, managed care will grow. The old indemnity fee-for-service type of arrangement, which was sort of hit-or-miss in terms of accessing health care, is not going to grow. This is based upon the performance of HMOs and managed care in terms of reducing and containing costs, and providing quality care that is equal to, or better than, fee-for-service.

In markets that have high concentrations of managed care, the quality of care, as evaluated by such gross measures as risk-adjusted mortality, is better than the fee-for-service system. Medicaid finds managed care attractive because it is a predictable, prepaid budgetary item, and satisfaction levels have been high.

**Q.** Given the fact that New Jersey still is a relatively immature market for managed care, can we assess its overall impact at this point?

**A.** This is definitely an immature market. We have a number of hospital beds that will not be used and hospital days per thousand in New Jersey are much higher than even on the West Coast. I see a continuing shakeout in the hospital system; more integrated networks with hospitals, nursing homes, and related services; use of existing capital facilities with not too much new investment; and a move toward large, multispecialty physician groups, embracing hundreds of physicians. While HMOs and managed care will grow, membership will increase but the number of companies will not increase.

**Q.** Do you see any kind of trend toward more point-of-service options?

**A.** All of our members now offer this option. In the past, joining an HMO often was a conscious, voluntary choice.



*If provider-sponsored organizations do not act like HMOs, they will have to change. While these plans are popular, their financial performance so far has been shaky.*

Today, many people are coming in because of employer mandates. It will be interesting to see how this works in terms of satisfaction levels. I think the performance will be very good.

In the focus groups that our national organization has run, choice is clearly an important factor to consumers. That's why we see point-of-service as an interim product right now. The fact is that people who buy point-of-service do not use out-of-network physicians very frequently. It is more like a security blanket.

**Q.** Some people see a trend toward more provider-sponsored plans in the future, which already is occurring in places like California and Minnesota. Do you see this trend emerging in New Jersey with such plans as First Option and Physicians' Health Plan?

**A.** It's hard to say right now because these plans have very limited experience in this state. The major question I have is

why that form of organization was developed. My guess is that it was in response to concerns by providers that they would be left out. Frankly, looking at the numbers, somebody is going to have to be left out if efficiency is going to be injected into the system. If provider-sponsored organizations do not act like HMOs, ultimately they will have to change or go out of business. And while these plans are very popular, their financial performance so far has been pretty shaky.

**Q.** Don't you think that the rise of these plans reflects the adversarial relationship that has developed between HMOs and physicians?

**A.** I think that when everyone sits down and looks at this objectively, HMOs need physicians to operate, and physicians cannot live without managed care. If I were a physician and I was told that this movement would mean that

somebody would have more say in the way I ran my life, and I might be losing some income as a result, I can see feeling some animosity. Ever since we've had third-party payers, nobody has asked a question about a physician's bill, by and large. The employers now are asking that question. Much of this has to do with the technology we have today to collect and analyze data, which often shows large discrepancies in cost and billing.

**Q.** Speaking of data collection, the New Jersey Department of Health and Senior Services (DHSS) has proposed regulations that would involve more monitoring of HMOs. What's your position on that?

**A.** We recognize that people want to understand how HMOs operate especially in terms of quality care, patients' rights, and financial solvency. But all we are asking for is a

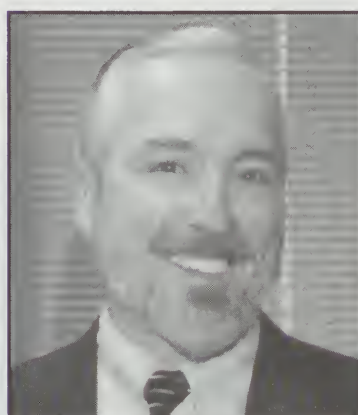
# *In the managed care environment, HMOs are the most regulated nationally, and in the state of New Jersey, HMOs are the only ones that are regulated.*

level playing field. Under these regulations, we'll be reporting a lot of information on our members, but the fee-for-service area won't be reporting anything, nor will PPOs. People will be looking at data and evaluating it, but compared to what?

Also, if you're a multistate health plan, and you have to set up five different data collection systems in five different states, that's neither very efficient nor informative. So we've argued to use standards set by NCQA, the nationally recognized accrediting body for network health plans. NCQA has done a lot of work on data reporting and has experts on the collection of the quality information and the problems and limitations involved with it. This would provide better standards for consumers who, most studies show, do not understand quality issues on health care "report cards."

**Q.** So you're asking for more balanced regulation?

**A.** We're getting blamed for every negative aspect of managed care. However, in the managed care environment, HMOs are the most regulated nationally, and in New Jersey



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Paul R. Langevin, Jr

we're the only ones that are regulated. PPOs and other kinds of networks do not need licenses to operate. We put up reserves against the money we collect to deliver health care. We have quality assurance mechanisms. Under the new DHSS rules, we'll have an independent third-party appeal, for which we'll pay. If these rules are good for us—and

we're only 20 percent of the market—they should be good for other plans. Fifty percent of the market is in self-insured plans.

**Q.** You've referred to the complexity of data collection on the managed care side. What about the complexity of data provision for providers? Is there any move toward standardization in terms of forms and paperwork?

**A.** We're working on a project to do that on a couple of different fronts, not just in New Jersey but in the entire northeastern region. This would include a standardized evaluation, so that a physician could fill out one form and be done with it. One of the biggest concerns is getting all the plans to buy in, but I don't sense a lot of resistance. It comes down to good business. I don't think a good business plan should mean going out of the way to upset physicians. If you can make their lives simpler, at little or no cost, let's do it.



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## Is health care an issue in next month's election?

David P. Rebovich, PhD

Dr. Rebovich is a political scientist and associate dean at Rider University, Lawrenceville. He is a contributor to *New Jersey Lawyer* and is a political commentator for several New Jersey, New York, and Philadelphia television and radio stations.

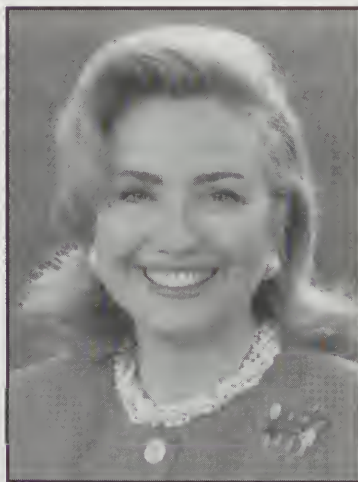
Republican presidential candidate Bob Dole talks of building a bridge to our past, while incumbent President Bill Clinton talks of building one to our future. In their convention and stump speeches and political commercials, both claim to have designed effective plans to address citizens' concerns about the quality of their lives and their long-term security. Each claims to have designed plans to balance the federal budget, cut taxes, produce more jobs, reduce crime, restore family values, and encourage family responsibility. According to the opinion polls, all of these issues are relevant to citizens as they consider how to

cast their ballots next month. But even the casual observer of politics knows that neither presidential candidate, and most folks seeking seats in the Senate and House of Representatives, have said much about an issue that is important to Americans. The issue is health care.

Oh yes, Clinton and Dole do have positions and, from their own perspectives, effective political "spins" on the issue. Once having threatened to veto any health care legislation that did not guarantee universal coverage for Americans, this summer President Clinton signed into law the Kennedy-Kassenbaum bill, which improves access to coverage for some 25 million workers and self-employed people. While hardly what he envisioned when he formed the task force headed by First Lady Hillary Rodham Clinton, the President praised the new legislation as "a long step toward the kind of health care reform our nation needs." Citing the nearly unanimous support that Dem-

ocrats and Republicans in Congress gave the measure, Dole proclaimed that the Kennedy-Kassenbaum bill represents "common sense reform" and should end once and for all the Clinton prescription of big government health care."

The charge that the President's plan for health care reform, which evolved through various incarnations and combinations of a single-payer system, managed care, and managed competition, entailed "big government" intrusion on the professional judgment of service



First Lady Hillary Clinton headed a health care task force.



deliverers and a decrease in patients' choices undermined any chance of major policy change. So argue Haynes Johnson and David S. Broder in their acclaimed book, *The System*. According to these renown political commentators, the Clinton administration's serious, if often convoluted, attempt to create a new health care system was undermined by the realities and dynamics of the new political system.

This main feature of this new political system is the ability of well-financed interest groups to redirect their efforts from lobbying government officials to the task of influencing, even manipulating, public opinion via commercials and mass mailings and passing off the results as what citizens "really think" at the grassroots level. In this case, the activists were health insurance associations and small business groups out to protect their own interests, who were encouraged by, and joined forces with, Republicans in Congress led by Newt Gingrich.

The fiery Speaker of the House clearly was against any attempts to expand government funding of health care because of its implications for the budget and deficit reduction. But his major concern was that Clinton's reform, in whatever form it would

take, might have made middle class citizens more dependent on government for services and increase their tolerance and expectation of what government should indeed provide for them. Gingrich was attempting to move the federal government in the opposite direction, by making it smaller, less expensive, and less intrusive. Health care would provide an

important test case of whether more citizens favored the Republicans "less government" ideology or the Democrats' "more government" one.

Whether due to intense advertising and politicking surrounding the issue or to deeper trends in public opinion, the polls did and still do show that Americans have consistent, if



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complex views, on health care reform. In principle, the majority of citizens support universal coverage. They support catastrophic care for the elderly. They want to choose their own physicians. But, the majority of Americans do not want or expect to pay more for health care but less. They are not interested in paying additional taxes for health coverage for someone else, especially unemployed or low-income individuals because that would simply be another welfare program, funded by an already fiscally stressed middle class.

When it became clear that Clinton's health care may entail some decreases in choice and increases in taxes to pay for those uncovered, the Republicans were easily able to fend off any reform. And Gingrich was able to use the health care issues to claim that President Clinton had liberal policy proclivities in other areas, and neither he nor his fellow Democrats could be trusted. This argument worked extremely well in the 1994 congressional elections, as the Republicans gained majorities in the U.S. Senate and House of Representatives.

But it worked less well when the newly powerful Republican Party had to unveil its plans to reduce the federal deficit while cutting taxes. Americans, especially senior citizens, who allowed themselves to believe that they would only gain under the Republicans tax and spending cutting plans soon discovered that Medicare spending would decline, co-payments would possibly go up, and managed care just may be required. Democrats jumped on what they saw as Republicans threats on Medicare, as well as on Social Security, the availability of college loans, job training programs, environmental regulations, and a woman's right to choose. These were all concerns of the middle class, the very people who thought the Republicans policies were designed to weed out wasteful spending on the undeserving and to help them.

In the current presidential and congressional campaigns, Bill Clinton and the Democrats are running strong on a plank that they will continue to protect citizens interests on the above issues. By focusing on these issues, each of which is highly salient to large numbers of citizens, the Democrats have avoided broad ideological discussions about liberalism and conservatism and have instead focused on creating coalitions to support their candidates.



In seeking to create their coalition, Clinton and the Democrats have talked about more topics in health care than keeping Medicare solvent or the portability of insurance policies. But not much more. They are for increasing federal spending on medical research and education, for better and more "prevention education" regarding tobacco and drug abuse, for child nutrition programs, and more rural and urban health care cooperatives. The much-touted bipartisan Kennedy-Kassenbaum bill will have little impact in New Jersey since the state already has similar programs in place. Regardless of the outcomes of the upcoming elections, health reforms at the federal level will likely be modest, owing to budget constraints and a lack of consensus among citizens about what they are willing to give up for reform. In that sense, health care is a symbolic issue this election year, and ironically the candidates who seem better able to protect the status quo will receive more voter support.

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## WHAT WENT WRONG WITH CLINTON'S HEALTH CARE REFORM?

*Bob Sommer*

**Mr. Sommer is executive vice-president, MWW/Strategic Communications, Inc., East Rutherford.**

A newly inaugurated President's first 100 days in office often are the make or break time for an administration. Since the swearing in of Franklin D. Roosevelt in 1933, much has been made of what a president needs to accomplish in this time to set the tone for his term. Indeed, every president since FDR has attempted to match his prodigious New Deal legislative agenda when he pushed numerous proposals through Congress in just over three months. This certainly is true of President Clinton.

When he assumed office in January 1993, President Clinton attempted to make comprehensive health care reform the hallmark of his presidency. In hindsight, his goal was much too difficult to achieve, but given the expectations the President established, the tone set was one that nearly led to his total demise. As the 1996 elec-

tion now is upon voters, it is timely to look back at the Clinton health care reform debate and understand what went wrong.

Should President Clinton have seen what he was risking? Absolutely. Did he realize the hole he was digging for himself? Not until it was too late.

Perhaps the political disaster of health care reform could have been avoided. The administration made three key mistakes.

*Mistake number one.* From the beginning, the Clinton health care team set the wrong tone and Americans were skeptical. When elected, although he comfortably won the Electoral College, Bill Clinton was chosen by fewer than one-half of the voters. Moreover, the Democrats actually lost seats in the House of Representatives and retained a comfortable, but hardly dominant, control of the Senate. Yet, officials in the fledgling administration believed they had a mandate for change and health care was

where Americans most wanted change.

Americans were worried about the cost of health care and their ability to maintain permanent coverage. Few, though, questioned the competence of physicians and health care institutions. People were not looking for comprehensive change. But the Clinton administration never paid much attention to the distinction between financial concerns and quality of care.

*Mistake number two.* The appointment of Hillary Rodham Clinton to head the legislative effort was a major tactical error. Even though she offered little in the way of health care credentials to lead such an important endeavor and possessed virtually no reputation in Congress, the administration clearly hoped the First Lady would succeed in taking the bold health care initiative directly to the American people. Americans, in turn, would let their members of Congress know they wanted the Clinton



## *As the 1996 election now is upon voters, it is timely to look back at the Clinton health care debate and better understand what went wrong for the President and Mrs. Clinton.*

plan passed. Unfortunately, this never came to pass.

Remembering that the President hardly had a mandate and that strong and varied interests opposed the Clinton plan—dubbed early on as the Health Security Act—the public never warmed to Mrs. Clinton or to the proposal. In this case, both the message and the messenger were rejected.

And who should be surprised? With terms like "managed competition" and "health purchasing alliances," few ordinary voters cared to follow the debate.

Think about the one image you recall from the interminable two-year debate. Many people would cite the Harry and Louise advertisements produced by the insurance industry. The administration's message? Few remember. In the final analysis, the President and his team never successfully explained the Clinton plan to the American people. Opponents were able to define the plan in negative terms.

With the pressure mounting about secret deliberations by the President's Task Force on

Health Care Reform, a bill that took too long to introduce, a well-organized and funded opposition, and a restive, albeit Democratic, Congress, the administration should have recognized that it had to scale back its plans for comprehensive change. Many allies in



*President Bill Clinton*

and out of Congress urged the President to do just that; in essence a "peace with honor."

*Mistake number three.* When the President realized his goal of comprehensive change was dead, the Republicans, sensing victory in the 1994 mid-term elections, were in no mood to compromise. Had Mr. Clinton moved earlier

to accept a modified plan, he likely would have gained enough Republican support to join with the Democrats and pass legislation that he could have signed into law.

As a result, the hottest political debate in 1993 and 1994 ended with literally no success for the President on which to base his campaign for re-election. But that is not to say the debate was a waste of time and money. Once relegated to the back burner and essentially ignored by the media, Congress eventually did act on the issue of concern to most Americans and the one Clinton should have made his administration's focus at the start of his term—portability. And without the harsh glare of unending attention, Congress recently convincingly responded to what most Americans wanted: secure health care coverage.

President Clinton seems to have learned from his mistakes by backing important but limited health care legislation. Ironically, he may campaign on his ultimate success in the health care arena. **NJM**

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## **SURVIVAL IN ADVANCED HODGKIN'S DISEASE AND NON-HODGKIN'S LYMPHOMA**

*Arnold D. Rubin, MD  
Gamal Tadros, MD  
Debra Hanley, MD  
Gerry H. Rubin, MD  
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**The authors are affiliated with the Bone Marrow Transplantation Unit, St. Joseph's Hospital and Medical Center, Paterson, and the Division of Hematology/Oncology, Seton Hall University, School of Graduate Medical Education, South Orange.**

Improvements in therapeutic modalities over the last two decades have led to a brighter outlook in patients with hematologic malignancies. Conventional chemotherapeutic approaches have provided long-term, disease-free survival (DFS) in many patients with acute lymphocytic leukemia, acute nonlymphocytic leukemia, Hodgkin's disease (HD), and non-Hodgkin's lymphoma (NHL). However, in all of these conditions, failure to achieve complete remission, or relapse following complete remission, precludes durable benefits from salvage treatment in the vast majority of cases.<sup>1-4</sup> This appears to be due to the develop-

ment of relative resistance to conventional doses of chemotherapy. Life-threatening toxicity, primarily directed at the bone marrow, has prevented attempts to escalate dosage of salvage therapy sufficient to counter this resistance. Thus, if bone marrow toxicity can be eliminated as the dose-limiting factor, then it would be possible to escalate doses up to the point of nonbone marrow-related toxicity. Fortunately, nonbone marrow-related toxicity, with a variety of agents in hematologic malignancies, occurs at much higher doses than marrow toxicity. This provides a window of opportunity whereby bone marrow transplantation can be utilized as a rescue from the major toxicity of dose escalation. If disease sensitivity falls within this window, then long-term, continuous complete remission is possible. In HD and selected cases of NHL, where bone marrow is free of disease, autologous marrow can be utilized for such a rescue without the risk of graft-versus-host disease (GVHD) inher-

ent in allogeneic bone marrow transplantation. In 1985, we began to treat patients with poor prognosis, and recurrent and drug-resistant HD and NHL with marrow ablative chemotherapy followed by autologous bone marrow transplantation (ABMT) to improve the response and long-term survival. Our results indicate that for these selected conditions, ABMT may represent the best possibility for achieving long-term freedom from disease for a majority of patients facing the grim prospect of inadequate salvage therapy.

**Patient profiles.** Between 1985 and 1990, 24 patients, 13 HD patients and 11 NHL patients, were accepted for ABMT based on the following criteria: age of 60 years or less; persistent or recurrent HD or NHL after a standard multi-agent chemotherapeutic regimen with or without radiotherapy; and bone marrow aspirate and biopsy immediately before the marrow harvest demonstrating a cellularity greater than 25 percent and no



## *Refinement of techniques and criteria for the selection of appropriate patients with Hodgkin's disease and non-Hodgkin's lymphoma likely will improve results for future patients.*

detectable tumor. Of the 13 patients with HD, 6 patients were male and 7 patients were female. All HD patients had nodular sclerosing type disease. Six of the 11 NHL patients were male and the remaining 5 patients were female. Five patients had low-grade lymphoma, 4 patients had intermediate-grade lymphoma, and 2 patients had high-grade lymphoma. Eleven of the 13 patients with HD and all the patients with NHL had refractory disease, which was defined as persistent or progressive disease despite full-dose conventional chemotherapy.

**Pretherapy and evaluations.** Before undergoing bone marrow ablative chemotherapy and ABMT, patients were subjected to cytoreduction of their existing disease employing conventional regimens, which were selected based on individual considerations. For HD patients, baseline CAT scan evaluation of residual disease was performed prior to the start of therapy and after two to three cycles to assess remission status. Patients demonstrating stable disease and

judged to be in the best obtainable partial remission (PR), were taken directly to transplantation. For the NHL patients, residual disease was further assessed by flow cytometric immunophenotyping and by DNA hybridization analysis.

Bone marrow was harvested from the posterior iliac crest using standard techniques. At the time of marrow harvest, a goal of at least  $2 \times 10^8$  nucleated cells/kg of the patient's body weight was sought. The marrow buffy coat was separated by centrifugation or with a Haemonetics V50 apheresis system and stored in vapor phase liquid nitrogen at  $-120^\circ\text{C}$ . Progenitor cell viability in the harvested marrow was assessed by CFU-GM assays.

Prochloroperazine and lorazepam antiemetics were used pretherapy and then as needed. Before receiving each course of cyclophosphamide, patients were administered normal saline at 250 cc/hr to establish a high-volume diuresis and the urinary bladder was irrigated using a three-way catheter immediately before and for 24 hours after the administration of the cyclophosphamide.

All patients were housed in single rooms on the transplant unit and during the time of neutropenia, patients were maintained in simple reverse isolation. On admission to the transplant unit, an indwelling triple lumen intravenous catheter was placed surgically. Trimethoprim-sulphamethoxazole was given orally. Blood products were transfused for hemoglobin levels less than 9 gm/dl or platelet counts less than 20,000/mm<sup>3</sup>.

**Ablative treatment.** The CBV ablative regimen consisted of BCNU, 300 mg/m<sup>2</sup> intravenously (IV) over 2 hours x 1 dose on day -6, cyclophosphamide 1.5 gm/m<sup>2</sup> IV over 2 hours daily x 4 doses on day -6 to day -3, and VP-16 400 mg/m<sup>2</sup> IV over 1 hour every 12 hours x 6 doses on day -6 to day -4.<sup>5</sup> The dose of cyclophosphamide was escalated to 1.8 gm/m<sup>2</sup> IV over 2 hours daily x 4 doses and the BCNU to 600 mg/m<sup>2</sup> in patients transplanted after 1989.

**Adverse effects.** All patients were maintained on IV hydration throughout the period of ablative therapy. Acute nausea and vomiting, though

*All patients were maintained on intravenous hydration throughout the period of ablative therapy. Nausea and vomiting were seen in all patients.*

variable in intensity, were seen in all patients. Twenty-two patients developed neutropenic sepsis and were treated with broad spectrum antibiotics. Eighteen patients had negative blood cultures; 3 patients had positive blood cultures for gram negative rods, *Pseudomonas*, and *Serratia* species; and 1 patient grew *Streptococcus viridans*. Six patients required antifungal therapy. Of these, 3 patients had *Candida esophagitis*, and 3 patients received antifungal coverage because of persistent fever despite broad spectrum antibiotics. All patients became afebrile after antifungal therapy.

One patient developed non-fatal temporo-occipital hemorrhage with focal seizures, together with cardiac dysrhythmia (PAT) and self-limited pericarditis. The majority of patients developed mild to moderate mucositis after ablative chemotherapy. One patient developed *Clostridium* positive pseudomembranous colitis; two patients required parenteral hyperalimentation during a period of severe mucositis; and one patient developed a vesiculopustular lesion on the right

shoulder that responded to acyclovir therapy. In all cases, toxicity was manageable and yielded no long-term deficits.

**Results.** Ten of 13 patients with HD (76 percent) achieved complete remission after ABMT and all are alive and free of disease at the last followup, with a remission duration of three to eight years (Figure 1). Engraftment of neutrophils occurred with a median time of 14 days (range 10 to 23 days) from the time of marrow infusion. Nonsupported platelet counts of greater than 25,000/mm<sup>3</sup> were obtained in all patients with a median time of 18 days postmarrow transfusion.

One patient developed a pulmonary relapse after 14 months. The patient subsequently underwent a second ABMT achieving a partial remission with evidence of marrow and continued pulmonary involvement. The patient expired after 2 months due to progressive disease. A second patient achieved partial remission after ABMT and went on to develop progressive disease after 12 months. This patient subsequently underwent a second ABMT and is free of dis-

ease at 7 years' post-transplant. A third patient achieved partial remission with ABMT and subsequently died of progressive disease.

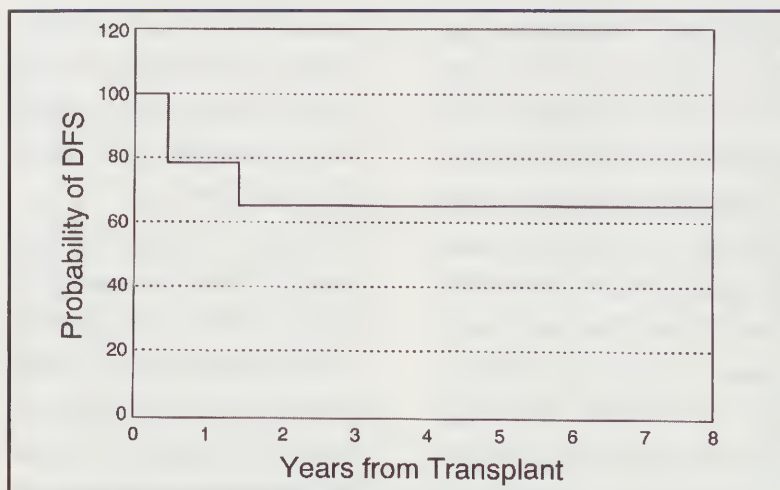
Six of 11 patients (55 percent) with NHL achieved complete remission after ABMT. Of the 6 patients achieving complete remission, 1 patient relapsed at six months and died due to progressive disease, 1 patient relapsed locally after one year and was rendered disease free with local radiotherapy, and 1 patient was free of disease at seven years post-ABMT. The five patients not achieving complete remission all expired due to progressive disease within two to three months of ABMT. None of the NHL patients were free of disease after salvage cytoreductive chemotherapy and before ABMT.

Using the actuarial survival method of statistical analysis, probability of survival after eight years was 65 percent for HD (Figure 1) and 18 percent for NHL (Figure 2).

**Discussion.** Approximately 6,000 patients with HD and nearly 25,000 with NHL relapse within 3 years of diag-



# *High-dose antineoplastic therapy, followed by ABMT rescue of patients with HD and NHL who fail initial induction therapy or who relapse, yields long-term, disease-free survivors.*



**Figure 1.** Probability of survival—non-Hodgkin's lymphoma.

nosis and are unlikely to be controlled on a long-term basis by a variety of conventional salvage regimens.<sup>6-8</sup> For those patients who are 60 years of age or less, a more aggressive regimen can be offered that takes advantage of the steep dose response curves of many agents commonly employed to treat these diseases. The first dose-limiting organ toxicity appears to be bone marrow related. Thus, with autologous bone marrow support, the dose of these agents can be escalated to a point short of the next organ toxicity limitation, which is predominantly gastrointestinal.<sup>9-11</sup>

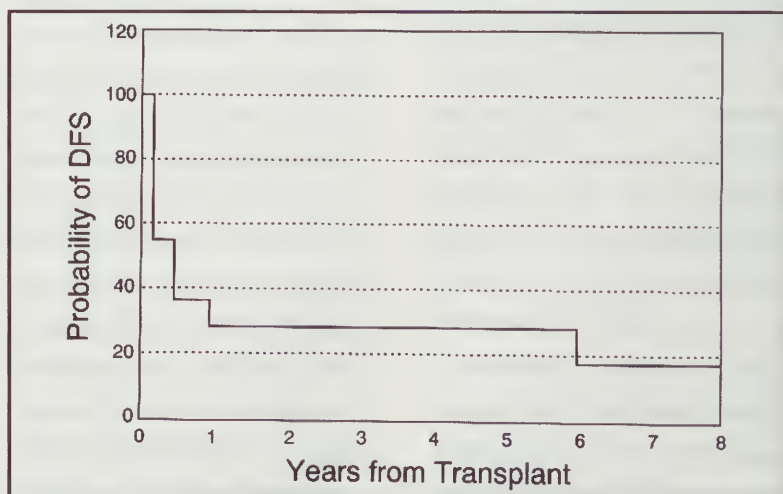
In our series of autologous marrow transplants, we encountered no morbidity related

to the harvest procedure, with the exception of mild lateral iliac crest discomfort. Observed toxicity was restricted to the treatment regimen. Transient renal toxicity from the marrow infusion was minimized by purification of the

marrow product and by adequate hydration. An obligatory period of granulocytopenia and thrombocytopenia represented the major source of regimen-related toxicity.

In our series, all patients with advanced HD and NHL were able to tolerate high-dose chemotherapy with minimal regimen-related toxicity. Toxic mortality was not encountered in this small series, but it has been reported by others to be as high as 4 to 21 percent.<sup>1, 10-13</sup>

Seventy-six percent of the patients with HD achieved complete remission. All patients except one patient are alive and free of disease. These patients showed a 65 percent probability of disease-free



**Figure 2.** Probability of survival—Hodgkin's disease.

*In this series, we were able to achieve long-term, complete remission in 18 percent of the patients from the non-Hodgkin's lymphoma group.*

extended survival. Similarly, 55 percent of patients with NHL achieved CR and showed an 18 percent probability of disease-free extended survival. Significantly, Hodgkin's patients who demonstrated resistance to definitive cytoreduction with conventional agents still achieved extended complete remission.

Two patients were never free of disease until ABMT. Patients with primary refractory disease usually are considered the poorest transplant candidates and it may be argued that these patients should not be eligible for a transplant procedure. In our series, 5 out of 23 patients had primary refractory disease, and 2 patients currently are alive and free of disease. Both these patients achieved complete remission only after ABMT. Thus, patients with primary-resistant disease who achieve a complete remission after ABMT can experience durable disease-free status.

**Conclusion.** The response to previous salvage chemotherapy has an important bearing on the outcome of ABMT. Jagannath demonstrated that

patients with relapsed HD who have good performance status and whose disease still is sensitive to salvage chemotherapy have a 75 percent projected three-year survival as compared to 18 percent in those patients with adverse risk factors.<sup>11</sup> Our results compare favorably. Takvorian has shown that high-grade NHL patients do poorly after ABMT as compared to low- and intermediate-grade NHL (47 percent versus 84 percent probability of disease-free survival).<sup>3</sup> In this series, eligibility required a complete remission before entry into the ABMT. In our series, none of the 11 patients in the NHL group achieved a complete remission or minimal disease status after salvage chemotherapy thus reflecting a drug refractory prognosis. Nevertheless, we still were able to achieve long-term complete remission in 18 percent of the patients from this group.

ABMT may be applied as a consolidative treatment for patients with advanced mixed or large-cell lymphoma who are at high risk for relapse following standard therapy.<sup>2,4,13,14</sup> These high-risk patients, who

have only a 20 percent likelihood of surviving five years with conventional therapy, may benefit from ABMT as part of their primary treatment.

Our results demonstrate that high-dose antineoplastic therapy followed by ABMT rescue of patients with HD and NHL who fail initial induction therapy or who relapse may yield a significant number of long-term, disease-free survivors. Refinement of techniques and criteria for the selection of appropriate patients likely will improve results. The introduction of hematopoietic growth factors and peripherally mobilized progenitor cells has decreased mortality and morbidity and has shortened the duration of myelosuppressive toxicity, and thus, hospitalization. While the resulting increased safety of the entire ABMT procedure will facilitate its application to a larger number of patients, the technique of ABMT, as it now exists, represents the therapy of choice for the HD and NHL patients 60 years or younger for whom conventional therapy has failed to offer a reasonable chance for survival.



*ABMT may represent the best possibility for achieving long-term freedom from disease for a majority of patients facing the grim prospect of inadequate salvage therapy.*

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Bill Berlin, PhD

## THE IMMUNIZATION ISSUE: ARE WE GIVING SHOTS IN THE DARK?

*If immunization seems like a fiscal and medical “no brainer,” why in New Jersey are one in four children between the ages of 19 and 35 months not adequately immunized?*

**When it comes to immunization, the messages are mixed, the information can be uncertain, and the conclusions often are a matter of perspective.**

For example, in February 1996, federal health officials proclaimed that national vaccination levels for children aged 19 to 35 months had increased to an all-time high of 75 percent. Just two months later, Dr. David Satcher, director of the Centers for Disease Control and Prevention, shifted the emphasis, telling a day care center audience that “more than one million preschoolers are not adequately immunized.” Moreover, a variety of recent studies suggests that only 37 to 56 percent of the 7.8 million two-year-olds in the United States are fully vaccinated.

In New Jersey, statewide retrospective surveys of first graders conducted between

1992 and 1996 have shown that no more than 52.8 percent of children in the state were appropriately immunized by 24 months of age. No large-scale survey data exist regarding childhood immunization coverage among private pediatricians and family practice physicians in New Jersey, but what we do know is not encouraging. Various informal surveys show a tremendous variation in immunization rates in the public clinic sector as well as among private physicians. Unpublished data from a recent study conducted by epidemiologist Dr. Barbara Goun and colleagues at UMDNJ-Robert Wood Johnson Medical School indicate that only 65 percent of children seeing physicians in private practice were immunized with the 4:3:1 series at 24 months.

If statewide immunization rates are disturbing, levels in urban areas are downright de-

pressing. A retrospective study of Camden first-grade students in 1992 found that at 24 months only 32.5 percent of the youngsters were fully immunized. The National Immunization Survey (NIS) of children aged 19 to 35 months, conducted between July 1994 and June 1995, estimated vaccination coverage levels with the 4:3:1 series at 60 percent for Newark, compared to 76 percent for New York City, and 86 percent for Boston.

Indeed, immunization is such a simple and cost-effective method of well-child care that anything short of universal coverage seems like a failure. CDC officials estimate that every dollar spent on a measles/mumps/rubella vaccination saves more than \$21 in health costs, while \$1 spent on a diphtheria/tetanus/pertussis vaccine saves \$30 in health costs.



*No large-scale survey data exist. Yet, various informal surveys show a tremendous variation in immunization rates in the public clinic sector as well as among private physicians.*

If immunization seems like a fiscal and medical "no brainer," why are one in four children between the ages of 19 and 35 months not adequately immunized?

The reasons are partly socioeconomic, partly systemic in terms of health care delivery, and partly, a matter of cost. Most low-income parents can obtain free or sliding-scale immunizations at federally qualified public clinics and community health centers. Payment may be more of a factor for working poor families that lack health insur-

ance, for whom the bill for a full series of immunizations can amount to as much as \$250.

While cost may not be a major hurdle, poverty and urban chaos loom large in the immunization puzzle. Unstable family situations, high rates of

single-parent households, and pervasive economic pressures may make inner-city parents more concerned with their children's next meal rather than their next shot. "For many urban parents, housing, crime, and family problems are daily challenges," says Ruth Guber-

barriers, including a shortage of public clinics, long waiting times for appointments, and difficulties in scheduling appointments. These problems were aggravated by obstacles, such as employment conflicts, unstable home environments, and misplaced apprehensions about the safety of vaccinations.

In addition, many urban families depend upon unreliable and sometimes inaccessible public transportation to get to a clinic or a doctor's office. Logistics can be difficult, espe-

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cially for a mother with three children who in inclement weather tries to get to a free clinic offering immunizations at restricted times. Responding to parental complaints about inconvenient hours and waiting for appointments, some clinics have set up "express lines" for

nick, program director of the New Jersey Comprehensive Immunization Program. "Getting shots for a child who is not sick may not be a priority."

Focus group sessions with socially disadvantaged mothers have identified a number of



# *Children need to be in a system of ongoing comprehensive health care through practitioners, whether they are in a private practice or in ambulatory care centers.*

children who just need immunization shots.

There is considerable pressure on all parents, regardless of socioeconomic background, to keep abreast of their child's immunization requirements, which today amount to at least 16 vaccinations. Thus, even though most pediatricians report that they ask parents if their baby has had all the shots, the answers they get may hang in the air. One recent study of children treated in a pediatric emergency room found that 89 percent of parents said that their child was fully immunized, but only 20 percent could indicate the exact number of immunizations their child had received.

Parents get little help from a fragmented health care system in which immunization data frequently fall through the cracks. More than 40 percent of children receive their pre-school

immunizations at two or more different health care facilities. An urban child, for example, might receive one vaccination at a public health clinic, and another in a physician's office, and may obtain occasional medical care from a hospital

Area Health Education Center in Camden.

The result is the absence of any standardized system for monitoring vaccinations and little or no followup when it comes to immunization. "I live in the suburbs, and I get a letter when my dog is due for shots," says Ruth Gubernick, "but I don't hear from my pediatricians about required immunizations."

On the provider end, the problem often is one of missed opportunities. Children brought to a physician's office for a sick visit may not be routinely assessed for immunizations. Contrary to the prevailing medical wisdom, some doctors simply will not vaccinate

even a mildly sick child. And despite CDC recommendations to maximize vaccinations, "a lot of pediatricians are hesitant to administer four vaccines in one visit," notes Kate Aquinas, assistant chief, Division of Immunization, New Jersey



emergency room. "Children need to be in a system of ongoing comprehensive health care through practitioners, whether they are in private practice or in ambulatory care centers," says Linda Bocclair, project manager for immunizations at the



Department of Health and Senior Services. More and more, providers are being encouraged to ask about immunizations at every visit. Indeed, experts on immunization urge an aggressive approach on many levels—a “permanent campaign” in the words of Dr. Barbara Goun—including greater outreach to parents, routine followups, and provider education. Community health centers in Trenton and Plainfield, for example, have raised immunization rates through programs in schools, day care centers, and work with teenage parents, abetted by an aggressive immunization policy within their clinics.

The major thrust in the state’s immunization campaign is the New Jersey Comprehensive Immunization Program (NJ-CIP) Demonstration Project in Camden, funded through a grant from The Robert Wood Johnson Foundation. With Camden as a model, NJ-CIP seeks to establish a centralized immunization registry that collects and integrates data from medical clinics, hospitals, private practices, and other sources. Using software developed by the University of Pennsylvania, the registry

allows authorized health care providers to access an individual child’s immunization history. The system also includes an algorithm, developed with the CDC, that projects when future shots are due and evaluates whether past vaccinations were administered at the correct time and at the appropriate dosage.

Now in its third year, the Camden project has registered an estimated 26,000 children up to the age of six years, and includes almost all the health care providers in the city. Although no formal evaluation of the project has been completed, “we’re definitely seeing increased immunizations at some clinics,” says Dr. David Carver, principal investigator and professor and chair, Department of Pediatrics, UMDNJ-Robert Wood Johnson Medical School.

While a statewide registry remains a long-term goal, Dr. Carver sees the next step as selective expansion of the model to other areas, notably New Jersey cities with high measles morbidity. Project software also will be made available to public health departments and managed care organizations in other parts of New Jersey.

Immunizations also should get a boost from the growth of managed care, especially among the Medicaid population. Unlike traditional indemnity plans, managed care organizations have placed greater emphasis on immunization, often including it as a quality assurance indicator operationalized through “report cards” requiring sites to immunize. Other states already have begun to evaluate health maintenance organizations for their immunization coverage levels.

Ideally, under managed care, youngsters will be part of a system in which they see primary care physicians for all services, thus facilitating recordkeeping, followup, and a full complement of vaccinations. The results, so far, are unclear. Medicaid managed care, as one example, is in its early stages, and many parents have not brought their children to a provider’s office for an initial visit.

With the use of new information technologies, the emergence of managed care, and greater emphasis on the importance of vaccinations, some observers are cautiously optimistic about the future. “Change is imminent,” says Kate Aquino. “It’s just a matter of time.”

## ADVANCES

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## HOW TO END THE EPIDEMIC OF VIOLENCE

*Analysis of current studies—cross-sectional, longitudinal, and experimental—concludes that the relationship between viewing violence and committing violence is reasonably strong.*

The authors are affiliated with the Department of Preventive Medicine and Community Health, UMDNJ-New Jersey Medical School, Newark.

Violent crime is devastating this country, creating pervasive fear in many communities, often imprisoning people in their houses during evenings and at night, and, in some cases, during the day.

The figures are appalling. Each year we suffer more than 20,000 murders, 2,000,000 assaults with injury, and 100,000 reported rapes. One million women a year require medical assistance because of battering. There are approximately 1.5 million prisoners in our jails and prisons. And when all costs, direct and indirect, are added together, the total is more than \$100 billion a year.

In his 1880 *Biographical Sketches*, Walter Bagehot observed, "Nine-tenths of mankind are more afraid of violence than of anything else." Surely, this is true today. One indication of that fear is found in the responses of first- and second-year medical students at New Jersey Medical School to a question about the number of murders in the United States. They were given choices of: 10,000; 20,000; 50,000; 100,000; and 200,000. In each class questioned, two-thirds of the respondents overestimated the number of homicides by twofold to eightfold.

There is increasing recognition that violence is a public health issue.<sup>1,3</sup> The medical profession is expected to take care of the physical injuries and the psychological consequences of violent behavior.

There have been many suggestions for coping with societal violence. We present five

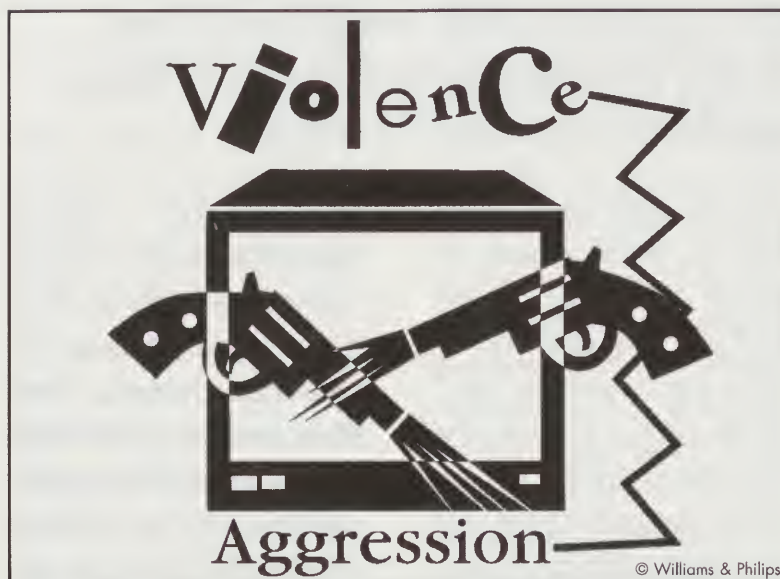
recommendations, most of which either are new or have a slightly different focus.

**1. Control violence on television, videos, and films, not by censorship but by creating economic choices.** There is increasing evidence that young people mimic the violence they see on television and in videos and movies.<sup>4,6</sup> The evidence is impressive. There have been almost 1,000 studies. A recent analysis of all these studies concluded that the relationship between viewing violence and committing violence is reasonably strong.<sup>7</sup> The studies tend to be divided into three types: cross-sectional, longitudinal, and experimental.<sup>6-10</sup> In the latter, typically, young children are shown either a short film with violence or a control non-violent film and their subsequent behavior is assessed.<sup>9,10</sup>

Faced with a large number of studies that link watching vio-



*Financial constraints have resulted in a progressive decrease of after-school activities and the percentage of students participating in such activities, leading to antisocial behavior.*



lence on television to aggression, violence, and criminality, what do the television and video industries say in response? In essence, they say: the link is not proved; watching violence may be good for people by serving as an outlet for aggressive tendencies; and the industries are only responding to what the public wants.

It is true that it is difficult to prove unequivocally that an act of violence by a given individual is due to seeing violence in the media. There always are many other influences, including family problems, living circumstances, and the use of

alcohol and drugs. But the denial shown by television, video, and motion picture executives is reminiscent of the argument used by leading figures in the tobacco industry that cigarette smoking was not proven to cause lung cancer. These executives kept up their denial long after the linkage was shown unequivocally.

When media representatives argue that viewing television violence does not result in aggressive behavior, they also point out that the overwhelming majority of television viewers will not be influenced by violent programming to behave ag-

gressively. They are absolutely correct.

But the issue is not what the majority do, but rather how the minority behave. After all, the overwhelming majority of Americans possessing guns will never use them to injure others. It is the minority who are of concern.

There must be a relationship between watching violence and aggressive behavior in some young viewers. The percentage of viewers whose aggression is significantly increased may be quite small, but there are so many millions of young viewers that even a small percentage translates into a lot of young people and a great many acts of violence.

What we propose is related to the deliberate use of violence for financial gain. It is very simple: we should preserve free expression but reduce the financial profits from that free expression when it involves violence.

We propose an expanded rating system. If a movie, video, or television program is

*If one combines deaths and injuries from violence and uses the public health model, then injuries and deaths due to use of guns are major public health issues, like cancer and heart disease.*

rated V (for extremely graphic violence) or E (for excessive violence), actors and actresses would have modest salary limits; producers and studios would have profit limitations, e.g. a maximum of 20 percent over cost; and advertisers would not be allowed to take a tax write-off for advertising these programs or they could be subjected to a "violence" surtax on profits. Monies raised from taxing the profits of media violence could be directed to community and school anti-violence activities.

Then we would see how many of these actors, producers, and advertisers are dedicated to violence for artistic purposes, and how many are just exploiting public tastes in violence to make money. This is not censorship. It would be an attempt to establish controls based on a societal public health judgment. As a society, we will be saying that we will not interfere with artistic expression even if the expression includes graphic violence. We will not risk interference with

the freedoms of speech and expression guaranteed in our Constitution and Bill of Rights. But we will not allow use of violence for exploitation or gargantuan financial profits.

## **2. Mandate extra-curricular activities in school for every youngster, and**



**allow no exceptions other than for valid medical reasons or after-school jobs.** Several decades ago schools offered a variety of such activities; more recently financial constraints have resulted in a progressive decrease in such activities and the percent-

age of students participating. The result is more young people with nothing to motivate or interest them, engaging in anti-social activities.

We must restore extra-curricular activities and mandate every student's participation. It would cost money, but in the long run it would save a lot of money and, more importantly, it would change a lot of young lives for the better. It is incredible that politicians and some educators thought we could just cut out these extra-curricular activities without incurring adverse effects. A recent U.S. Justice Department report noted that the peak time for violent crime by youths ages 6 to 17 was from 3 to 6 P.M., between the end of the school day and dinner time.<sup>11</sup>

## **3. Spend substantial amounts of money to develop community centers, so that young people have alternatives to drugs and crime.**

Community centers should have facilities for various sports, music, and dances that partici-



*Those persons who have committed nonviolent crimes would be given up to two years to refocus their lives, develop a goal-directed orientation, and learn a work ethic.*

pants find exciting and interesting. This is not mollicoddling young people. It is practicing preventive medicine. If young people have nothing to do, they will get involved in socially undesirable activities, and their role models will be those individuals who have been successful in such activities. The peer pressure will be to participate in antisocial activities. Boredom among young, energetic persons is a prescription for trouble.

Community centers with exciting and constructive activities can go a long way toward changing the current situation and alleviating boredom. Furthermore, the community centers might attract some of the school dropouts who, of course, would not be involved in school extra-curricular activity. This school dropout population is particularly prone to criminal activity.

**4. Establish restart camps in every state.** Many illicit drug abusers (including small-time sellers), those

charged with gun possession, and others who have committed nonviolent crimes would be given up to two years to refocus their lives, develop a goal-directed orientation, and learn a work ethic. They would be expected to do hard work and pay for their upkeep. There now is enthusiasm for the establishment of boot camps at federal and state levels. But there is no magic to establishing these camps. Most camps being developed plan on keeping the residents for only a few months, and the environment often is inordinately harsh and repressive. If camps are to be effective, residents will have to stay at least a year, and the camps will have to be under the control of motivational psychologists, social workers, occupational experts, and epidemiologists. And each program will have to be rigorously evaluated. One reason for insisting on a one-to-two year residence period in these camps is the necessity for improving reading and writing skills, and for job training. Job

placement upon discharge and during followup is critical. Short-stay boot camps that do not enable an individual to function in society, for the most part, are a waste of money.

**5. Treat guns as a risk factor for a disease (violence) requiring primary prevention (removal of the risk factor).**

If one combines deaths and injuries from violence and uses the public health model, then injuries and deaths due to use of guns become numerically as important a public health issue as cancer and heart disease.

The medical profession recognized the role of tobacco as a risk factor for cancer and heart disease and then mounted a highly successful public health campaign. Removal of handguns and assault weapons from our communities should be an equally strong public health imperative. There is no doubt we could do it if we had the will power and determination. If gun possession carried a mandatory, no-parole,

*We surely can reduce the level of violence in our society. It will take a consensus on the necessity for prudent action, and it will take time, effort, and money.*

seven-year sentence and that sentence was independent of any other sentence for a crime and had to be served in full before any other sentence started (no concurrent sentence), and if illegal handgun sellers were given a ten-year, no-parole sentence plus an additional sentence related to use of specific guns in a crime (as accessories to the crime), then handgun possession and use in crimes would diminish swiftly and profoundly. At present, we clearly have no willingness to act so forcefully. We would argue the medical profession should take the lead in specific recommendations to remove this obvious risk factor.

Societies do not start out being violent; they acquire violent and aggressive tendencies over time. No other developed society is as violent as ours. We surely can reduce the level of violence in our society. It will take a consensus on the necessity for prudent actions, and it will require time, effort, and money. But we must act, and

act now, before this cancer of violence overwhelms the entire society.

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## CREATING A HEALTH SYSTEMS DEPARTMENT AT A MEDICAL SCHOOL

*A department of health systems needs to be created and directed by clinicians who would provide instruction, pursue research, and offer expertise on issues of politics, business, and law.*

**The authors are fourth-year students, UMDNJ-New Jersey Medical School, Newark.**

In the past, medical schools were able to train physicians in the art and science of medicine and set them in the marketplace to fend for themselves. With rare exceptions, most graduating physicians were able to establish successful practices with little difficulty. Today's environment is more complex, with more restrictions and fewer prospects available to graduating residents. It is obvious that becoming a doctor has become more difficult, encompassing significant aspects of business and politics, so that financial and career success no longer is a virtual guarantee.<sup>1,3</sup> In spite of all this, medical schools have responded slowly to educating medical students and residents about these changes. Furthermore, the paucity of faculty role models involved in health care politics perpetuates the notion that students, residents, and fellows

can continue to ignore these issues until a later date.<sup>4</sup>

Since a medical school has easy access to training physicians, a central location for community physicians, a reputation for objectivity, appropriate educational resources, and an influential role in medicine, it is the logical choice for developing a department dedicated to these issues.

This new academic department would pursue the following goals: to educate physicians, to research health system problems, and to offer its resources as a health care consultant. Instead of providing individual medical care, this department would apply its formed ideas to improving and redesigning health care on a system or population level.

**Teaching mission.** Physicians are introduced to new legislation, new health care companies, and new economic pressures on a daily basis. These factors influence how physicians practice, where they practice, and how much they

can charge for their services, yet most receive little to no instruction regarding these issues. Medical school and residency provide an opportune time for physicians to become familiar with these practice realities and to prepare them to make better decisions about their future.

The curriculum for medical students constantly undergoes revisions but changes revolve mainly around new teaching methods and the reallocation of time between the basic and the clinical sciences. Conspicuously absent are curriculum changes that reflect the increasing role of politics, business, and law in medicine. Most graduating medical students' backgrounds on managed care, federal health programs, and legal medicine are derived from a handful of required lectures during their first two years of medical school. These lectures usually are insufficient and delivered at a time when medical students are unable to grasp their importance due to lack of ward experience.



*Instruction to New Jersey medical residents on health care system issues is even more important because the lack of information translates into a business disadvantage in the near future.*

Acknowledging that instructional time already is crowded during medical school, short lectures and seminars could be employed throughout the four years or heavily during the fourth year before graduation. The national licensing boards also should recognize the importance of these topics and emphasize them on standardized examinations. Other educational methods could be employed including: senior electives, summer internships, reference guides for medical students, courses for senior medical students, and a listing of externship opportunities.

Instruction to residents on health care system issues is even more important because the lack of information translates into a business disadvantage in their near future. Instead of requiring lengthy business or law courses, a series of lectures throughout training would provide a sufficient background on topics as starting a practice, contracting with insurers, and buying a practice. A few clinical departments have taken the initiative by providing some of this information to residents, but it needs to be provided for all residents

in every department. Rather than having ten departments organize ten seminars, educational programs should centralize to improve content and efficiency. In addition, state medical societies and alumni could be invited to take a more active role in teaching residents about the realities of practice.

The private practitioner and hospital staff who meet the era



of managed care with great difficulty also may benefit from advanced health care courses. Unfortunately, courses sponsored by health consultant companies, pharmaceutical firms, or MCOs are plagued by questions regarding their validity due to the bias of the supporting organization. The final reliable source of information

remains the medical journal and the products of the medical school. Therefore, courses offered by a department of health systems are better received than those sponsored by other groups. Private physicians may come to see the university not only as a clinical referral center for complicated cases, but also as an objective source for periodic re-education on health systems issues. This also will help to bridge the gap between private and academic physicians as they work together to adjust to the changes in the health care industry.

**Research mission.** Insurance companies and MCOs sometimes pay executives millions of dollars to extract more profit from the health care system, often without sufficient emphasis on the quality of patient care. As of yet, there is no counterpart within the medical profession assigned to oversee the quality of care while developing cost-saving strategies. Although individual specialties may occasionally publish a cost-comparison between treatment modalities, the current pace at which this type of research is pursued is too gradual.

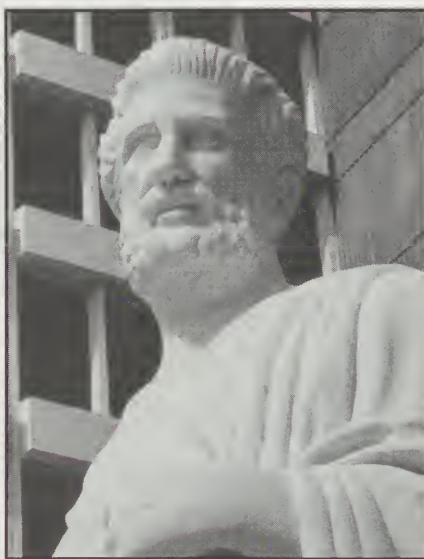
*Outcomes research is the most rapidly expanding aspect of medical investigation, but most medical centers are not organized to efficiently provide this type of information.*

Outcomes research is the most rapidly expanding aspect of medical investigation, but most medical centers are not organized to efficiently provide this type of information. A department of health systems would enable the synthesis of clinical data, generated by the different departments, with financial information, provided by the hospital accounting office, to produce information about the most cost-effective medical practices. Clinical pathways and guidelines could be structured and rewritten based upon updated, dual-field information. Furthermore, a health systems department could conduct research regarding innovative health care delivery systems, efficient business practices, optimal case-mixes, and quality assessments of MCOs.

In addition to on-site research, grants and study fellowships could be offered to medical students, residents, and other staff physicians for off-campus work. Currently, medical students are offered opportunities in Washington, DC, as legislative fellows, while postgraduate physicians can participate in the national Robert Wood Johnson Health

Policy Fellowship Program.<sup>5-7</sup>

The opportunity for combined professional degrees such as an MD-MBA also could be an option, with the department offering a true interface between the disciplines and not simply two parallel graduate degrees.<sup>8-10</sup>



*Statue of Hippocrates at UMDNJ-Robert Wood Johnson Medical School.*

Well-designed studies published in a peer-reviewed journal will remain the cornerstone of physician motivation to change current patient management methods. If the philosophy of cost-efficient care is to be stressed across the medical community, research on health care systems must be performed at the medical school

and must undergo the critical review process. The department of health systems could be the springboard from which private hospitals and physicians begin to share updated, efficient medical practices, thereby decreasing the cost of health care.

**Resource mission.** Unadulterated by a financial goal, this academic department could provide objective data to the various components of the health care system. Consultation services to practitioners, businesses, and governments could be offered on a contractual basis to fund the department. Examples may include a grant by an MCO to compare the costs of medical versus surgical management of a condition; a medical society may desire a compilation of outcomes performance between MCOs; or a state government may seek innovative health system designs for providing charity care. The private hospital staff and individual practitioner benefit from having access to unbiased information about current practice design, medicolegal issues, cost-effective clinical pathways, and the other resources of the health systems department.



*Staffing the department of health systems will require a careful search of physicians and nonphysicians with diverse backgrounds and varied education and experiences.*

**Faculty recruitment.** Staffing the department of health systems will require a careful search of physicians and nonphysicians with diverse backgrounds. Such qualifications may entail an experience of clinical practice or facility management, a strong interest in teaching and research, and an affiliation with a political, business, or legal group. Faculty appointments to individuals with a business or law degree will provide a better picture of real-world health care accessibility.

Moreover, there are many successful physicians who seek to retire from the grueling demands of private practice and whose expertise and experience could be shared with the ongoing trainees of medicine through associate appointments. To supplement the faculty, nonphysicians with expertise in the political or legal arena also could be retained as consultants.

**The future.** The era of managed care or global budgeting will be the working environment of the 21st century physician. Regardless of initiative or knowledge, a few physi-

cian or nonphysician leaders cannot solve the health care crisis. Similarly, a few national health policy centers staffed by a handful of multidisciplinary health care experts cannot reduce health costs while maintaining quality care.

The development of a department of health systems can achieve these objectives by teaching the necessary fundamentals for dealing with practice realities, researching cost-containment issues, and providing resources for private groups who seek objective information.

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## SELLING YOUR PRACTICE? WHAT YOU NEED TO CONSIDER

Michael P. Weiner, Esq

**Mr. Weiner is a member of the Business Law and Health Care Law Groups, Stark & Stark, P.C., in Princeton. He is a member of the National Health Lawyers Association and the Health and Hospital Law Section of the New Jersey Bar Association.**

As managed care gradually extends its presence in New Jersey, and the accompanying competition for practitioners and patients increases, there has been a marked increase in the number of practices that are being purchased by hospitals or merged into multidisciplinary groups. These obviously are significant events in the professional lives of health care practitioners, and deserve careful consideration prior to entering into any binding arrangements. This article will summarize many of the crucial points

to be considered by any practitioner involved in such a transaction.

*What is being sold?* There are critical differences in the legal and tax ramifications of selling shares of a professional service corporation as compared to selling assets of a professional practice. In the first instance, the purchaser of the shares will take title to not only the assets of the practice, but also to its liabilities. In the latter case, it is possible for the purchaser to acquire only the assets, and to leave the seller with the responsibility for satisfying the liabilities.

*How has the practice been valued?* A professional practice is, at its core, a business, and like any business it has a value distinct from any other business. A variety of methods exists for placing a value on a professional practice. However,

the central issue seems to be how to value the "goodwill" of the practice, which is classified as an intangible asset, unlike the desks, examination tables, and laboratory equipment that are referred to as tangible assets. You need not accept the purchaser's word for what the practice may be worth. It is advisable to retain your own qualified appraiser to perform an independent financial analysis of your practice.

*How is the purchase price to be paid?* If you are selling your practice to an institution, you may be fortunate enough to receive all cash at closing. However, if you are selling to another practitioner or group, it is likely that the purchaser's financial obligation to you will last for several years. In such circumstances, you will want to be sure to have adequate protection in the event of a default in the payment of the long-term



*In New Jersey, there has been a marked increase in the number of practices that are being purchased by hospitals and that are being merged into multidisciplinary groups.*

obligation, such as the right to repossess the assets of the practice. Also, if the practice is being purchased by an individual or group, you may wish to consider requiring the purchaser(s) to purchase life and disability insurance coverage in an amount at least sufficient to cover the long-term portion of the purchase price payment.

*Compensation.* Many practice sales include a continuing employment arrangement for

the selling physician(s), with the terms and conditions typically set forth in a written employment agreement. How will compensation be calculated? Will there be only a base salary, or will there be a potential for additional compensation if cer-

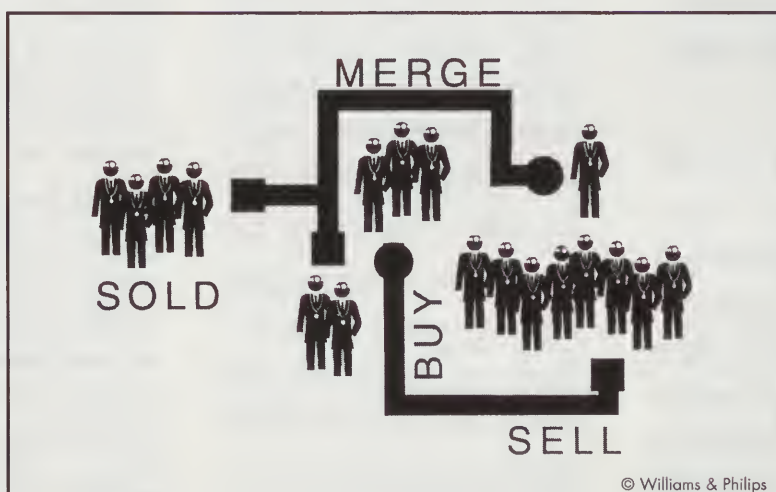
tain predetermined productivity benchmarks are met? If so, what are those benchmarks, and who will maintain the financial records necessary to determine whether they have been achieved?

*Accounts receivable.* It is no secret that one of the direct

must be made to ensure that the purchaser will use its best efforts to collect, and will pay over to the seller, the accounts receivable that exist at closing. One possible solution is to permit the purchaser to retain a percentage, say 10 percent, of any of the seller's accounts receivable it collects after closing. This provides a clear incentive for the purchaser to use all the best efforts to collect these accounts on behalf of the seller.

*Continuing ex-*

*penses/liabilities.* In those circumstances that various expenses or liabilities are being transferred to the purchaser, for example, office or equipment leases, the lease agreements must be reviewed to determine whether the land-



results of managed care on the business of health care is the increase in a practice's accounts receivable at any point in time. If the purchaser is not interested in acquiring, or the seller is unwilling to sell, the accounts receivable, provisions

*It is no secret to anyone that one of the direct results of managed care on the business of health care is the increase in a practice's accounts receivable at any point in time.*



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lord's or leasing company's consent to the transfer is required. Also, if various office employees continue with the practice following its sale, it is important to clearly determine which party is responsible for such items as accrued vacation and sick pay.

**Malpractice protection.** If the selling professional has maintained "claims-made" malpractice insurance coverage, it will be necessary to maintain "tail" insurance after closing. In

any event, it is in the seller's best interest to be sure that the purchaser maintains adequate malpractice insurance, especially if the practice will remain at its current location, to provide an extra level of protection for the seller against claims asserted by transferred patients.

**Restrictive covenant.** Whether the transaction is structured as an outright sale, or a sale with a continuing employment relationship for the selling pro-

fessional, it is more than likely that a restrictive covenant will appear in the purchase and/or the employment agreement. Although the courts traditionally do not like agreements not to compete, they will uphold them, particularly in the context of a practice sale. The only rule of thumb is that the restrictions must be "reasonable" as to duration and geographical distance. A typical restrictive covenant may be for two years and five to ten miles, but may vary based upon the nature and location of the practice.

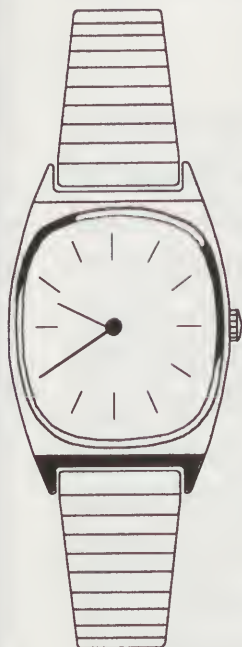
**Conclusion.** This is obviously not an exhaustive list of the issues to be addressed in a practice sale situation. However, the article provides a starting point for structuring a transaction that will proceed smoothly, with a minimum of risk to the buyer and seller. Ignoring any of these items could result in some unpleasant surprises down the road.

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# DO YOU HAVE THE RIGHT TIME?

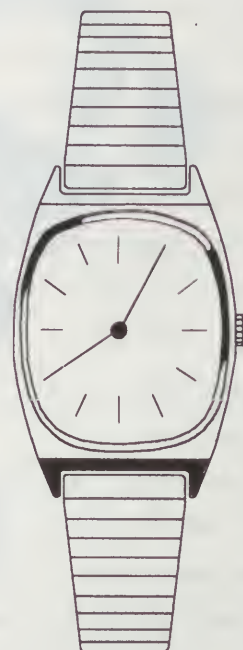
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pain in your right  
arm and side ...



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that it **WAS** a  
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# COMMENTARY

## Building excellence in an academic medical center

*Harvey A. Holzberg*

Providing cost-effective care while maintaining an academic medical center's high standards of excellence in the era of managed care is a challenge. Robert Wood Johnson University Hospital's (RWJUH) success in meeting this challenge is accomplished, in part, through a comprehensive effort in re-engineering and restructuring that has enabled us to remain agile. As a result, physicians, nurses, technicians, and other health care professionals can devote more of their time to working directly with patients and their families. In addition, we've developed very efficacious systems that enable us to continue to provide measurable quality care in the most cost-effective manner.

As the core teaching hospital of the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School, with all of the attendant costs thereof and because we provide tertiary and quaternary patient care, our rates, in the early 1990s, were probably 30 to 35 percent higher than the community hospitals in this area. Because the medical school is only 25 years old, we did not have 100 years, as did some of the other academic medical centers, to build up the kind of huge infrastructure that's fast becoming anachronistic. We stayed relatively lean and mean because we built our infrastructure in the more recent health care environment with its requirements for cost-effective care.

We developed a strategic plan whose components included clinical protocols to streamline care and optimize quality; cost efficiencies realized through restructuring and cross-training of personnel; improvements and/or additions to existing services; and the establishment of the Robert Wood Johnson Health System with affiliated community hospitals and health centers. We also partnered with the medical school to set up an affiliated primary care physician network and develop programs that are responsive to community needs.

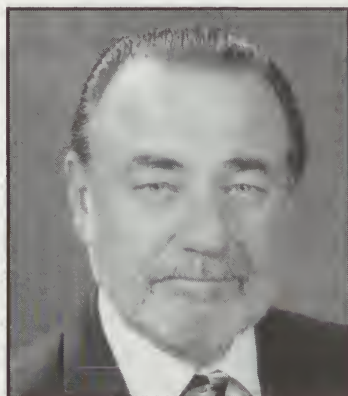
As a result, the hospital is well positioned in the managed care arena, and in fact, as in prior years, has contracts with every major insurance company doing business in New Jersey.



**Clinical protocols—OPTIMaps.** In the mid-1990s, we began to look at the most expensive and most common of our diagnoses as candidates for clinical protocols, or OPTIMaps, developed by physician-led teams. The first clinical protocol for elective coronary artery bypass grafting reduced the average length of stay (LOS) and realized an average drop in charges of 6 percent. Quality remained uncompromised. Since then, more than a dozen protocols have been developed for other high-cost, high-volume diagnoses that have maintained or improved quality and produced cost efficiencies. Objectively, patient satisfaction is high, and the American College of Health Care Executives awarded our OPTIMaps program its citation for outstanding innovation in health care in 1995.

**Re-engineering leads to new national initiative for emergency care.**

Re-engineering efforts have included ProAct II, a nursing cross-training initiative; major refining of the patient floor host/hostess roles; and the 1995 restructuring of our emergency department (ED). The key feature of the ED restructuring, a 15/30 minute guarantee that patients will be seen by a nurse within 15 minutes and by a physician within 30 minutes or the hospital pays the bill, has met with unqualified success. The results have been gratifying. ED visits rose 15 percent in 1995; nurses have met their 15-minute goal 99 percent of the time and physicians their 30-minute goal 96 percent of the time. Once again, in an objective evaluation,



Harvey A. Holzberg

the program was described as an "extraordinary guarantee that exceeds industry standards" in an August 1995 issue of *Modern Healthcare*, a national health care publication.

**Enhanced services.**

Other improvements for physicians and patients include:

- Creation of a 24-hour transfer center enabling physicians to transfer a patient to RWJUH with only one telephone call.
- Establishment of The Heart Center of New Jersey, a 110-bed "hospital within a hospital" specializing in the diagnosis and treatment of cardiovascular disease. Both Prudential Insurance Company and Aetna

Health Plans selected RWJUH as a cardiac center of excellence.

- Expansion of services including a separate pediatric hematology/oncology unit to augment the full range of services in our Children's Hospital; a bone marrow transplant unit; the Center for Nurse Midwifery;

the Vascular Center of New Jersey; the Center for Alternative and Complementary Medicine; and our Chinese-American Medicine Initiative.

**Robert Wood Johnson Health System.**

In 1993, the hospital formed the Robert Wood Johnson Health System. The members currently include nine community hospitals, four health centers, and three long-term care facilities locat-

## COMMENTARY

ed throughout five central New Jersey counties.

The system is based on three principles: expanding the value to patients and hospitals of the relationship with the medical school; maintaining the commitment to remain a regional network; and developing a decentralized structure with hospitals, health centers, and physicians forming management services organizations to coordinate care specific to community needs. The system has offered members access to the Transfer Center and to OPTIMaps and the development of a uniform formulary and system-wide MIS capabilities. Future efforts will include single signature contracting.

*Quality remains the focus.* With each innovative change, we've maintained our commitment to the highest standards of quality. In 1995, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) awarded us a score of 99 out of a possible 100—the highest score of any institution in New Jersey—and accredita-

tion with commendation. Only 4 percent of hospitals nationwide, and 1 percent of academic medical centers, achieve this rating. Perhaps the most extraordinary compliment the hospital received from the survey team was their observation that we had become a truly high-level academic medical center without losing the caring, personal service usually associated with smaller community hospitals.

We were pleased to be ranked the number one hospital in a six-county central New Jersey region in the 1995 Survey of America's best hospitals conducted by *US News and World Report* in ten specialties. We also received a national ranking in that same survey for our neurology services.

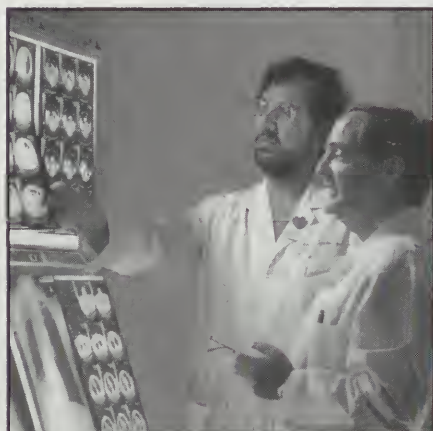
*Conclusion.* During 1995, the hospital experienced increases in every key measure of patient service. We experienced a 17 percent increase in admissions and a 10 percent increase in occupancy, all the while providing cost-effective care. Despite having the highest acuity index in New Jersey, our average LOS had declined to 5.3 in 1995 from 6.6 in 1993 and currently is 4.8. And the cost differential between RWJUH and community hospitals has narrowed considerably.

As managed care proliferates in our region, the hospital will continue to support our mission to provide the highest quality patient care, research, education, and community outreach and successfully meet the new challenges of providing health care into the next century.

Mr. Holzberg is president/CEO of Robert Wood Johnson University Hospital, New Brunswick.



## COMMENTARY



Physicians at University Hospital review x-rays.



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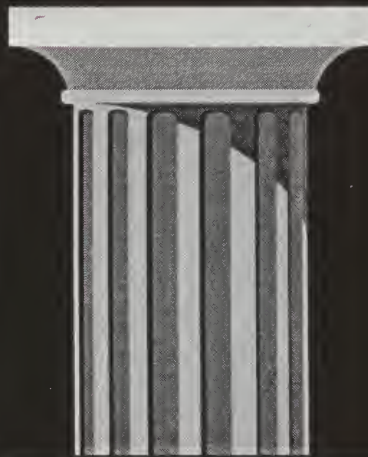
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## DO WE NEED TO READ BETWEEN THE LINES OF HEALTH CARE CONTRACTS?

Ritamarie Rondum

*Policy language is prone to misinterpretation. Most worrisome is the need for the patient to develop survival skills necessary to effectively manage managed care.*

For example, absolutely “not covered services” under any of the policies are “Conditions related to behavior problems or learning disabilities.” I wondered, “What if the behavior is the illness?” One carrier’s answer to this question is that some patients will trash an office. My response is, if so, why not call the police instead of withholding health care?

Policy language so prone to interpretation stimulates a tangle of ethical issues. When accepting the insurance, does the physician accept the insured? The compliant and the recalcitrant? Some out-of-state insurers expand the definition of “behavior” to “abusive,” “disruptive,” “unruly,” and “uncooperative” and see grounds for health insurance termination. Is this language New Jersey’s ride down the slippery slope to patient dumping? If so, where does physician responsibility begin and end?

Standard health maintenance organization (HMO) contracts assert that “physicians maintain

After I began reading health insurance policies line-by-line, I wondered if doctors ever read the contracts their patients sign. I’m not a doctor, lawyer, or health care professional, so I was reading with a layperson’s eye. But some sentences in the state’s standard individual policies startled me.

*The doctor/patient relationship is what makes health care work—not the fine print in coverage contracts. And it works in HMOs.*

managed care plan like a health maintenance organization (HMO), the delivery of health care under the coverage depends on the trust between patient and doctor.

I appreciate the opportunity to respond to the commentary by Ritamarie Rondum. Ms. Rondum’s thesis, as she comments at length, on language from various health coverage policies, appears to be that if you read the fine print you discover the exceptions are the rule. Her translation is that she thinks health coverage policies are written to deny coverage.

Her thesis is flawed. The proof is that we spend \$1.4 trillion a year on health care in the United States. The bulk of that is paid by third parties whether they are private indemnity plans, HMOs, or government plans like Medicaid and Medicare. By the way, Medicare and Medicaid are governed by laws and regulations that define and set coverage

Under any form of health coverage, the delivery of good health care comes down to the relationship between patients and doctors—between each individual and the doctor. No matter what a coverage plan says in the fine print—and, yes, the fine print matters—whether coverage is through a fee-for-service policy or a

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## Rondum

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the physician-patient relationship” and are solely responsible for all medical services rendered. Managed care plans assert that the insurer is “not responsible for a Provider’s failure or refusal to render services or provide supplies to persons eligible for benefits under this Policy.”

Look at all standard policy definitions, and you’ll find: “ILLNESS (OR ILL). A sickness or disease suffered by You. A Mental or Nervous Condition is not an Illness.”

All policies define the not-an-illness mental or nervous condition as follows, “A condition that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical cause. A Mental or Nervous Condition includes, but is not limited to, psychoses, neurotic, and anxiety disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neuro-hormonal systems. In Determining whether or not a particular condition is a Mental or Nervous Condition, we may refer to the current edition of the *Diagnostic and Statistical Manual of Mental Conditions* of the American Psychiatric Association.”

This is reassuring to the nonprofessional, except for the choice of the permissive “may.” But, perhaps, “may” leaves the door open to treatment, rather than closing it.

Contract language aside, it is physician acquiescence to medical decision making behind the corporate veil that threatens the physician-patient relationship. The definition of medically necessary and appropriate is crafted with care: “Services or supplies provided by a recognized health care Provider that We Determine to be: (a) necessary for the symptoms and diagnosis or treatment of the condition, Illness, disease, or accidental injury; (b) provided for the diagnosis or the direct care and treatment of the condition, Illness, disease or Accidental Injury; (c) in

*continued to page 65*

## Kapulskey

*continued from page 63*

limits and, in that respect, serve the same purpose as private policies.

First, as to Ms. Rondum’s suggestion that a recitation of health coverage contracts reveals a caveat emptor for patients/consumers, the issues are the same in any kind of health coverage contract, whether it is a straight indemnity fee-for-service plan, an HMO, a PPO, or a POS plan. Every insurance policy of any kind would seem equally as formidable, whether for automobile coverage, homeowners coverage, or life insurance. Insurance policies are legal documents written in express detail to avoid disputes later.

Issues such as who is covered, when they are covered, and for how long a person is covered always are critical and sometimes disputed no matter what form of health coverage is contracted. That does not mean we should not continue to discuss them, to clarify them, and to be aware of them. But, it also does not mean they are in any way unique to managed care.

Much more importantly, policy or coverage plan language should not dictate a physician’s approach to patient relationships. My own experience as a physician participating in managed care is that there is no usurpation of my timely professional judgment on behalf of my patients or any incentive to treat them differently because they may belong to an HMO instead of to a traditional insurance plan. Indeed, studies have found that in most cases a physician’s decision about a course of treatment is the same regardless of the third-party source of payment—whether an HMO or other managed care plan or an indemnity carrier.

HMOs do require adherence by physicians to demonstrated, effective medical practice and to constant evaluation of the performance of doctors and hospitals. Those are good things for everyone, but especially for patients. Health services provided by HMOs are high in quality and require the active par-

*continued to page 65*

## Rondum

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accordance with accepted medical standards in the community at the time; (d) not for Your convenience; and (e) the most appropriate level of medical care that you need." "The fact that an attending Practitioner prescribes, orders, recommends, or approves the care, the level of care, or the length of time care is to be received, does not make the services Medically Necessary and Appropriate."

Insurers are not practicing medicine without a license but merely describe for what they will pay. The cautionary language introducing the definition of medically necessary and appropriate, and throughout the policies is commendable but, unfortunately, the insertion of the warning about physician decision making does little to inspire trust between the patient and physician.

Most worrisome is the need for the patient to develop the survival skills necessary to effectively manage managed care. Because the health care delivery system relies on the telephone, patients need language and reading comprehension skills that are at least equal to those of the contract writers.

Imagine this scenario: "Thank you for calling. If you have a touch tone phone, please press #1 now. If you are experiencing pain, please. . . . If the pain is in the lower left quadrant, please. . . . If accompanied by fever, diarrhea, or vomiting, please hold to speak with one of our representatives."

It seems to me that it is during this first contact, this exchange, that the initial determination of medical necessity is made. And it is the skills and aptitude of the patient that will be tested in the effort to secure the promised health care. For the burden is

*continued to page 66*

## Kapulskey

*continued from page 64*

icipation of patients so that doctors can decide and deliver good care.

It is surprising that Ms. Rondum laments that HMOs are staying out of the physician/patient relationship. Usually the complaint is that HMOs interfere in the relationship. Of course, she offers the notion that HMO health care is delivered over the telephone. It is not. It is delivered in doctors' offices and hospitals, the same as it always has been delivered to patients.

First, last, and foremost, physicians practice medicine and serve the interests of their patients. New methods are evolving in health care as HMOs and other health care organizations try new approaches to keep patients well and to curing those who are ill.

But management and method do not change the underlying relationship between patients and physicians.

It is based on the expectation and trust that patients have in the competence and ability of their doctors and on the obligations of physicians to fulfill their patients' expectations and live up to their trust.

The doctor/patient relationship is what makes health care work—not the fine print in coverage contracts. It works just as well in managed care environments like HMOs as it always has in the past.

Scott E. Kapulskey, MD, maintains a family practice in Bordentown and Tabernacle. He is a member of the Board of Trustees of the New Jersey Academy of Family Physicians and serves on regional HMO physician advisory boards.

**NJM**



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## Rondum

*continued from page 65*

upon the patient to describe the condition, to have accurate recall, or memory, reasoning, and introspection—maybe under stress—to secure the benefits of the managed care agreement.

Under the standard managed care policy, it is the patient who must secure authorization, pre-approval, or comply with the utilization review process for everything from a physician's recommendation for an inpatient admission to nutritional counseling. In the utilization review process, if the patient fails to obtain a requested third opinion for a surgical procedure or hospital admission and, it turns out, the procedure was indeed medically necessary and appropriate, the insurer will reduce payment by 50 percent.

The standard HMO contract is more forgiving of the use, misuse, faulty use of language, or physician decision making. Should the patient have received medically unnecessary and inappropriate care, the patient will not be required to reimburse the insurer if the care was provided by the primary care physician without notification to the patient that the care was not medically necessary and appropriate.

A curious phrase stands out under "Exclusions" in the individual HMO standard contract and other standard health benefits plans, services or supplies will not be provided if "needed because You committed or tried to commit a felony or to which a contributing cause was Your being engaged in an illegal occupation." Non-HMO policy language differs somewhat and is even more peculiar, withholding services or supplies "needed because You engaged, or tried to engage, in an illegal occupation or committed, or tried to commit, a felony." "Tried," I wondered? What about this "innocent until proven guilty" business?

One insurer's response was that if someone sustained a shotgun wound to the chest during the robbery of a liquor store, the insurer certainly wasn't going to pay. What if the person had been paying premiums for 25 years, I asked? No matter. This exclusion is based on a New Jersey insurance statute.

Eligibility for health care as a dependent in all of the state's standard contracts excludes the most innocent of all. Policy language is unambiguous: "Your Child Dependent's Newborn—A Child born to Your Child Dependent is not covered under this Policy." This prohibition appears not to be tied to any specific statute and may rely on the perceived need to have that newborn slide into the hands of a caseworker. Or, fixing responsibility may be hampered by the

rights of the newborn's parent or parents, the age at which one is eligible to sign a contract in New Jersey, or the emerging issue of grandparent's rights. Meanwhile, in New Jersey, where's the baby? In the six states where health care is provided through the Harvard Community Health Plan there is coverage for "The child of a Subscriber's eligible dependent, until such time as the parent of the child ceases to be eligible for coverage as a Dependent of the Subscriber." If it is true that

only one in eight of New Jersey's children are covered by health insurance, another look at this prohibition seems warranted.

Surely, in the system we now have there is an interdependence between the doctor, the patient, and the insurer. A kind of triage, if you will, with the patient the least likely to be heard. Principles of patient autonomy and the practice of and respect for the doctrine of informed consent may only be heard in whispers. At a minimum, how about an office handout outlining the doctrine of informed consent. But then again, who will pay for that?

*Ms. Rondum is a member of the Board of Directors of the New Jersey Individual Health Coverage Program.*



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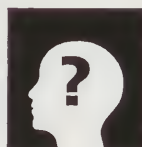
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October 10-11, 1996  
Holiday Inn, Princeton  
609/452-2400

### **Orthopaedics Symposium**

October 11-12, 1996  
Marriott, Somerset  
908/560-0500

### **Nephrology Society Monthly Meeting**

October 15, 1996  
Overlook Hospital, Summit  
908/522-2000

### **Management of Hepatitis C**

October 16, 1996  
Location to be announced  
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Warren Hospital, Phillipsburg  
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### **Postprandial Hyperglycemia**

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Union Hospital  
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### **Stroke Update: Evaluation and Treatment**

October 16, 1996  
Marriott, Philadelphia  
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October 17, 1996  
RWJMS, New Brunswick  
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### **Radiological Society Meeting**

October 17, 1996  
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### **HINT Conference**

October 18, 1996  
MSNJ, Lawrenceville  
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ASJ, New York  
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Scheie Eye Inst., Philadelphia  
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The Clara Falk Franks Lecture: Emerging New Infectious Diseases in Pulmonary Medicine .....	Dennis G. Maki, MD
Crisis in Antibiotic Resistance .....	Dennis G. Maki, MD
Evaluation of the Patient with Chronic Dyspnea .....	Donald A. Mahler, MD
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November 4, 1996  
UMDNJ, Stratford  
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November 6, 1996  
Union Hospital  
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### **Integrating TB Management for the HIV Infected Patient**

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Veterans Medical Center, Lyons  
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### **Vascular Society Meeting**

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201/325-2060

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November 7-9, 1996  
Disney Yacht & Beach Resort  
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### **Ob/Gyn Meeting**

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The Manor, West Orange  
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### **Postprandial Hyperglycemia**

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Newcomb Medical Center, Vineland  
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Woodbridge Developmental Center  
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201/533-5000

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November 22, 1996  
UMDNJ, Stratford  
609/566-6000

### **Women's Health**

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*Eugene Braunwald, M.D.*

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OCTOBER 9th

#### Advances in Pulmonary Medicine

*David M. Center, M.D.*

Division of Pulmonary Medicine, Boston University Medical Center, Boston, MA

OCTOBER 16th

#### Advances in Cardiovascular, Renal and Cerebrovascular Medicine with Adenosine

*Ami Iskandrian, M.D.*

Professor of Medicine  
Director, Nuclear Cardiology, Division of Cardiovascular Diseases, Allegheny University Hospitals, Center City

*Luiz Belardinelli, M.D.*

Professor of Medicine and Pharmacology  
Department of Medicine, University of Florida School of Medicine, Gainesville, FL

*Christopher Grange, M.D.*

Associate Professor of Medicine  
Duke University School of Medicine, Durham, NC

*Robert Mentzer, Jr., M.D.*

Professor and Chairman  
Cardiothoracic Surgery, Director, Cardiopulmonary Transplantation, University of Wisconsin Hospital and Clinic, Madison, WI

OCTOBER 23rd

#### Disorders of the TSH Receptor

*Martin I. Surks, M.D.*

Professor of Medicine and Pathology  
Albert Einstein School of Medicine, Head, Division of Endocrinology and Metabolism, Montefiore Medical Center, Bronx, NY

### OCTOBER 1996

OCTOBER 30th

#### Molecular Abnormalities of Cardiac Dysfunction

*Milton Packer, M.D.*

Professor of Medicine and Pharmacology, Chief, Division of Circulatory Physiology, Director, Center for Heart Failure Research, Columbia-Presbyterian Medical Center, New York, NY

### NOVEMBER 1996

NOVEMBER 6th

#### The Changing Face of Community-Acquired Pneumonias: The Impact of Pneumococcal Resistance

*Daniel N. Musher, M.D.*

Professor of Medicine, Microbiology and Immunology

Baylor College of Medicine, Chief, Infectious Diseases, VA Medical Center, Houston, TX

NOVEMBER 13th

#### H.pylori—Revelation to Revolution

*David A. Peura, M.D.*

Professor of Medicine  
University of Virginia Health Sciences Center, Associate Chief, Division of Gastroenterology, Charlottesville, VA

NOVEMBER 20th

#### Progression of Renal Disease in African Americans with Hypertension

*George L. Bakris, M.D.*

Associate Professor of Preventive and Internal Medicine

Department of Preventive Medicine, Director, Rush Hypertension Program, Rush-Presbyterian-St. Luke's Medical Center, Chicago, IL

NOVEMBER 27th

No Grand Rounds

### DECEMBER 1996

DECEMBER 4th

#### Genetic Models of Hypertension

*Richard P. Lifton, M.D., Ph.D.*

Associate Professor of Medicine, Nephrology, and Genetics

Yale University School of Medicine, Assistant Investigator, Howard Hughes Medical Institute, New Haven, CT

DECEMBER 11th

#### Cardiac Auscultation for the Generalist and Office Practice

*Bernard L. Segal, M.D.*

Clinical Professor of Medicine  
Division of Cardiovascular Diseases, Allegheny University Hospitals, East Falls, Philadelphia, PA

*Gerald Scharf, D.O.*

Clinical Professor of Medicine  
Division of Cardiovascular Diseases, Allegheny University Hospitals, Center City, Philadelphia, PA

*Dean G. Karalis, M.D.*

Clinical Assistant Professor of Medicine  
Division of Cardiovascular Diseases, Allegheny University Hospitals, Center City, Philadelphia, PA

*Farooq Chaudhry, M.D.*

Professor of Medicine  
Division of Cardiovascular Diseases, Director, Cardiac Echo Labs, Allegheny University Hospitals, Center City, Philadelphia, PA

*John J. Ross, Jr., RCPT, RDCS*

Research Assistant Professor  
Division of Cardiovascular Diseases, Allegheny University Hospitals, Center City, Philadelphia, PA

DECEMBER 18th

#### Advances in the Use of Interferon

*Moshe Talpaz, M.D.*

Professor of Medicine  
University of Texas School of Medicine, Interim Chairman, Department of Bioimmunotherapy M.D. Anderson Cancer Center, Houston, TX

DECEMBER 25th

No Grand Rounds

## Wednesday Medical Seminar Series—8:30 a.m. to 3:30 p.m.

OCTOBER 9, 1996

#### Advances in Pulmonary Medicine Treatment of COPD

Course Director: Edward S. Schulman, M.D.  
Visiting Professor: David M. Center, M.D.  
Boston University Medical Center

OCTOBER 16, 1996

#### Advances in Cardiovascular, Renal and Cerebrovascular Medicine with Adenosine

Course Director: Ami Iskandrian, M.D.  
Visiting Professors: Luiz Belardinelli, M.D.,  
University of Florida School of Medicine  
Christopher Grange, M.D., Duke University School of Medicine  
Robert Mentzer, Jr., M.D., University of Wisconsin Hospital and Clinic

DECEMBER 11, 1996

#### Cardiac Auscultation for Office Practice

Course Co-Directors: Bernard L. Segal, M.D.,  
Allan B. Schwartz, M.D., Farooq Chaudhry, M.D.,  
Dean Karalis, M.D., Gerald Scharf, D.O.,  
John J. Ross, Jr., RCPT, RDCS

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

**Full Disclosure Statement:** All faculty participating in continuing medical education programs sponsored by the Allegheny University of the Health Sciences are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

**Statement of Accreditation:** The Allegheny University of the Health Sciences is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. The Allegheny University of the Health Sciences designates 1.0 credit hour of Category I of the Physician's Recognition Award of the American Medical Association for each hour of attendance at these continuing medical education activities. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

This program is eligible for 1.0 credit hour for each hour of attendance in Category 2A of the American Osteopathic Association.



## FALL '96

### **TB and the Law**

December 2, 1996

UMDNJ, Newark

201/982-4267

### **Tumor Board Conference**

December 4, 1996

Hyatt Regency, New Brunswick

908/873-1234

### **Orthopaedic Update**

December 7, 1996

Kessler Conference Center, West Orange

201/731-3600

### **Infection Control in the HIV Era**

December 4, 1996

Veterans Medical Center, Lyons

908/647-0180

### **Postprandial Hyperglycemia**

December 6, 1996

Marlboro Psychiatric Hospital

908/946-9081

### **Telemedicine**

December 11, 1996

Health Sciences Library Assoc.

201/996-2326

## *Here's what we are covering in November 1996*

### ⇒ Why are the experts concerned about the overuse of antibiotics?

Writers Bill Berlin and Karen Gillespie uncover the real truth behind the use of antibiotics.

### ⇒ How has hospice care changed the delivery of health care?

To recognize National Hospice Month, we present an overview of hospice care in New Jersey.

### ⇒ What is New Jersey Health Initiatives?

Director Pauline M. Seitz outlines New Jersey Health Initiatives. NJHI has awarded \$13 million dollars to 50 programs across the state over the past 12 years.

### ⇒ Can New Jersey HEALTHDECISIONS build consensus in health care delivery?

Learn about this organization's grassroots efforts to increase public awareness and participation in health care decision making.

### ⇒ Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.

# editorial guidelines

## Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

## Copyright

In compliance with the Copyright Revision Act of 1976 (effective January 1, 1978), a transmittal letter or separate statement accompanying material offered to *New Jersey MEDICINE* must contain the following language, and must be signed by all authors.

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## Publication Policy

*New Jersey MEDICINE* will review original unpublished materials on topics relevant to health care professionals in New Jersey. All submissions are subject to peer review and are edited to conform to the style of *New Jersey MEDICINE*. Receipt of materials will be acknowledged. Final decision is reserved for the editor. No direct contact between the reviewers

and the authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648.

## Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.









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continued from page 80

Craig J. Anmuth, DO, was appointed medical director of Bacharach Institute for Rehabilitation, in Pomona. Dr. Anmuth is a member of the AMA, MSNJ, and the Atlantic County Medical Society.



Craig J. Anmuth, DO

The AMA appointed Joseph N. Micale, MD, to a five-member team to select members for the Federation Coordination Team. Dr. Micale is a past-president of MSNJ and a member of the Hudson County Medical Society.



Joseph N. Micale, MD

MSNJ member Marc Rothman, MD, has been named the medical director at Hampton Behavioral Health Center, in Westhampton. Dr. Rothman is a member of the AMA, the Camden County Medical Society, and the Camden County Mental Health Board.

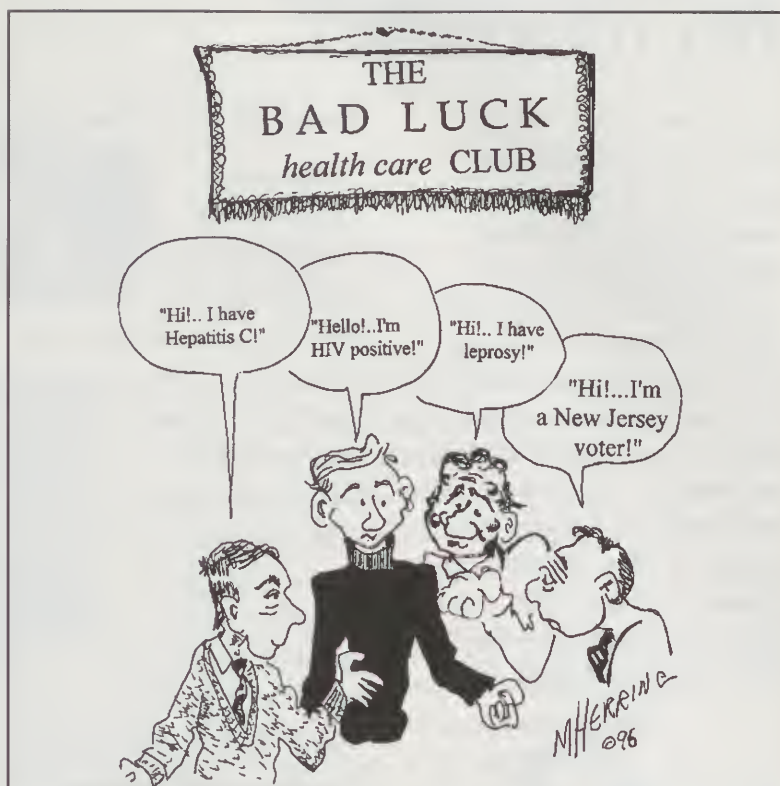


Marc Rothman, MD

### Table.

ABC Company (Primary)  
\$1,000 charge  
UCR: \$800  
Amount paid: \$640  
(80 percent of \$800)  
Balance: \$360

XYZ Company (Secondary)  
\$1,000 charge  
UCR: \$750  
Liability as primary: \$600  
Liability as secondary: \$360  
Savings as secondary: \$240



Our cartoonist is Marvin E. Herring, MD. Dr. Herring is a member of MSNJ and is professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine.

### Advisories to insurers

Two recent actions taken by the New Jersey Department of Insurance and Banking occurred after proactive inquiry by MSNJ.

**Group coordination of benefits (96-17).** Some carriers may be violating regulations in N.J.A.C. 11:4-28 regarding coordination of benefits (COB). Specifically, some carriers cap a specific benefit at the highest usual, customary, and reasonable rate of all the companies responsible for payment of the claim regardless of whether the carrier is the primary and secondary payor in the order of benefits determination.

A bulletin issued by Commissioner Elizabeth Randall clarified that a patient who is covered by a primary and a secondary policy—as occurs, for example, when both a husband and a wife have family coverage from their separate employers—can receive up to 100 percent payment on a claim, as shown in the Table.

**Physician DEA number (96-18).** Insurance companies have been requested to rethink their use of physician DEA numbers on insurance claim forms. To request physicians to use the DEA number when submitting a claim violates the confidentiality of the number. To avoid such a compromise, the Department of Insurance requests DEA numbers be used solely for the purpose for which they were originally intended and not as general provider identification numbers for insurance claims.

For detailed copies of bulletin 96-17 and 98-18, call MSNJ, at 609/896-1766, extension 259.





# MSNJ SUPPORTS NEW FDA TOBACCO RULE

Supporting the new FDA tobacco rule, MSNJ issued a statement in favor of the administrative rule. To keep tobacco out of the hands of young people, key elements of the rule include: minimum age of 18 to buy tobacco products; a ban on vending machines and self-service displays; a ban on kiddie packs, loosies, or free samples; and a ban on mail-order sales. To reduce the appeal of tobacco products to youth, the rule states: a ban on billboards within 1,000 feet of



schools/playgrounds; advertising for billboards, outdoor and in-store, limited to black and white text only; advertising in publications with significant youth readership limited to black-and-white text only; a ban on brand-name sponsorship of sporting or other events, only corporate name sponsorship permitted; and a ban on brand-name hats, t-shirts, and gym bags. The FDA also proposed the six tobacco companies with significant sales to children should educate them about the dangers associated with tobacco products and called for a \$150 million annual fund for educational programs.

## Protease inhibitors added to list of HIV/AIDS treatment drugs

Department of Health and Senior Services Commissioner Len Fishman announced that protease inhibitors will be available to those enrolled in the AIDS Drug Distribution Program (ADDP). The drugs, which will be added to the ADDP formula-ry, are 3TC (Epivir), saquinavir (Invirase), and indinavir (Crixivan); they have been approved by the FDA. Research into protease inhibitors indicates that some people with HIV/AIDS



Len Fishman,  
Commissioner

taking these drugs in combination with AZT and 3TC may stay healthy for a longer period. The drugs work by blocking an enzyme important to the growth of the HIV virus.

Many view this as a positive step in HIV/AIDS treatment. David Troast, chair of the Governor's Advisory Council on AIDS, praised the department

for including protease inhibitors and the governor for her support.

## MSNJ welcomes new staff directors

MSNJ announces the following staff changes: JaNoel L. Bess, director of membership; Lawrence Downs, project director of NEW JERSEY BREATHEs; Diana C. Gore, director of officer services; and Kurt B. Hoenigsberg, director of outreach. JaNoel will be responsible for membership records, membership recruitment and retention, and continu-

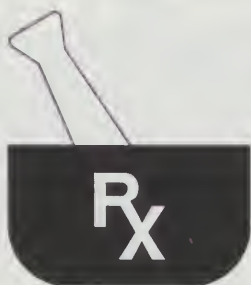
ing medical education. Larry will facilitate NEW JERSEY BREATHEs and other public health activities. Diana will be responsible for the Board of Trustees, officer and House of Delegates matters, and the AMA Delegation. Kurt will focus on marketing efforts, especially the newly formed Medical Review and Accrediting Council (MRAC).

## Annual raffle for the Physicians' Health Program

The Auxiliary to the New Jersey Association of Osteopathic Physicians and Surgeons and the MSNJ Alliance are sponsoring the 1996 Annual Physicians' Health Program Raffle on November 6, 1996. The first prize winner will be awarded a \$10,000 travel gift certificate and the second prize is a \$5,000 travel gift certificate. Tickets are \$100 each. To purchase tickets, contact MSNJ at 609/896-1766, extension 206.

*continued on page 79*

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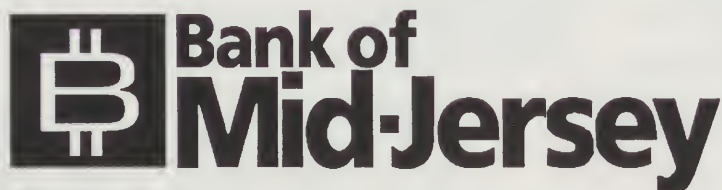
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*Health Care in the Garden State*

November 1996

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WITH AMA's  
DR. JIM TODD

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New Jersey MEDICINE

## newsWATCH

The AMA has released its authoritative *Physician Marketplace Statistics* for 1995, and the findings suggest that New Jersey has a long way to go before becoming a "mature" managed care environment. To illustrate: Among the ten largest states, our favorite jurisdiction ranked by far the lowest in the proportion of physicians practicing in groups of more than eight physicians, with 4.3 percent. Pennsylvania, by contrast, was second lowest with 11.1 percent.

Last year, New Jersey similarly registered the lowest average practice size (4.1 physicians), the lowest share of employed physicians (28.9 percent), the highest share of physicians in two-physician practices (22.2 percent), and the highest percentage of revenues directly from patients (26.4 percent). It also had the highest medical equipment expense per physician (\$15,500, in 1994), and—happily but perhaps not for long—the lowest average wait for an appointment by new patients (5.4 days).

But, Garden State physicians also sported the lowest average number of surgical procedures per week (2.4, or, if assisting procedures are not counted, 2.0) and the lowest average number of hours spent in professional activities per week (51.7).

**Numbers are one thing, and quality is something else. Or is it? The New England Journal of Medicine is completing a six-part series on quality of care, intended to spark physicians into protecting their leadership role in health care by participating more convincingly in the debate over quality.**

**"This," admonishes series editor David Blumenthal, MD, MPP, of Massachusetts General Hospital, "is a challenge for which few physicians are prepared."**

An editorial by **Marcia Angell, MD**, and **Jerome P. Kassirer, MD**, introducing the series warns that the "doctor-patient dyad has been replaced by the health plan-employer dyad" and questions whether consumers will have the power to select plans or providers on the basis of quality. "Worse," declare Drs. Angell and Kassirer, "the pressures of the marketplace dictate more attention to cream-skimming than to quality enhancement" as HMOs labor to improve their scores on quality by enrolling the healthiest patients. And, the journal editors observe that "most doctors now are double agents—working for their patients but also for their companies."

More positively, series authors note progress in developing the tools used to measure and improve quality—progress so dramatic, writes **Mark R. Chassin, MD, MPH**, of Mount Sinai School of Medicine, that "it is time for physicians to embrace quality measurement and improvement enthusiastically." As listed by Dr. Blumenthal, these tools include clinical epidemiology (pioneered by **John Wennberg, MD**, in the studies on physician practice variations), outcomes research, computer technology, and applications of total quality management borrowed from industry. Dr. Blumenthal predicts as imminent the nearly universal placement of computers on physicians' own desks.

HMOs, too, have come in for criticism in the top medical journals for failing to address the quality imperative satisfactorily so far. **John E. Ware, Jr, PhD**, of the New England Medical Center spiced up the pages of the *Journal of the*



American Medical Association (JAMA) with study results showing that 54 percent of Medicare beneficiaries enrolled in HMOs experienced declines in physical health, compared with only 28 percent of Medicare beneficiaries who obtained care on a fee-for-service basis, in Boston, Chicago, and Los Angeles between 1986 and 1990. Dr. Ware's findings were featured prominently in trade periodicals and in the popular press—inspiring editorial cartoons and other profound analyses.

Disclosed in the same October 2 issue of JAMA were results of another study of HMO outcomes, in which the mortality rate for high-risk babies was 29 percent higher inside HMOs than outside. Led by **Ciaran Phibbs** of the VA Palo Alto Health Care System and using California data, this study also found that level 3 neonatal intensive care units produced a 38 percent lower mortality rate.

The newest scorebook on quality, **HEDIS 3.0**, is scheduled for release in January. (The official draft was summarized in these pages in September). And, the AMA is weighing in with a nationwide survey of physicians' judgments about the health plans they serve. New York-northern New Jersey and Philadelphia-southern New Jersey are two of the 22 markets covered in the survey, with data collection ending November 1.

Still vibrant, the **US Agency for Health Care Policy and Research** is moving forward with plans to develop a computerized quality measurement network (**QMNet**) to assess providers' performance in delivering appropriate clinical services, providing those services safely and competently and in a timely fashion, communicating with patients effectively, and producing desired outcomes. So, physicians' practice survival as well as their leadership positions are at stake as quality gains center stage.

Concerns for quality also stimulated the **Health Care Financing Administration (HCFA)** into spawning new impediments to HMOs forcing physicians to take on more financial risk. Starting January 1, Medicare HMOs that leave physicians at risk for 25 percent or more of total compensation must so notify beneficiaries and must provide reinsurance.

**Here, Medicaid director Velvet G. Miller has confirmed the administration's retreat from plans to seek a comprehensive Medicaid waiver that would enroll all Medicaid recipients, including nursing home residents, in HMOs. But, managed care remains the only prospect for welfare recipients, and Ms. Miller still is committed to developing a managed care mental health and substance abuse program.**

Interested in **medical savings accounts (MSAs)**? Responding to the new federal legislation, New Jersey's Small Employer Health Benefits Program Board has paved the way for carriers to offer MSAs. And read MSNJ Past-President Dr. Louis Keeler's essay in this issue.

Proposals to create ten new ambulatory surgery centers were listed recently by the Department of Health and Senior Services, which is granting expedited review to the plans under new, more relaxed certificate-of-need guidelines (see "Mailstop" section).

Finally, Senate Minority Leader **John A. Lynch** of New Brunswick, but not Senator **Raymond Lesniak** of Elizabeth, is under fire for being too heavily influenced by contributions from optometrists. Expect new campaign finance reform proposals, adorned with loopholes.

**Neil E. Weisfeld**

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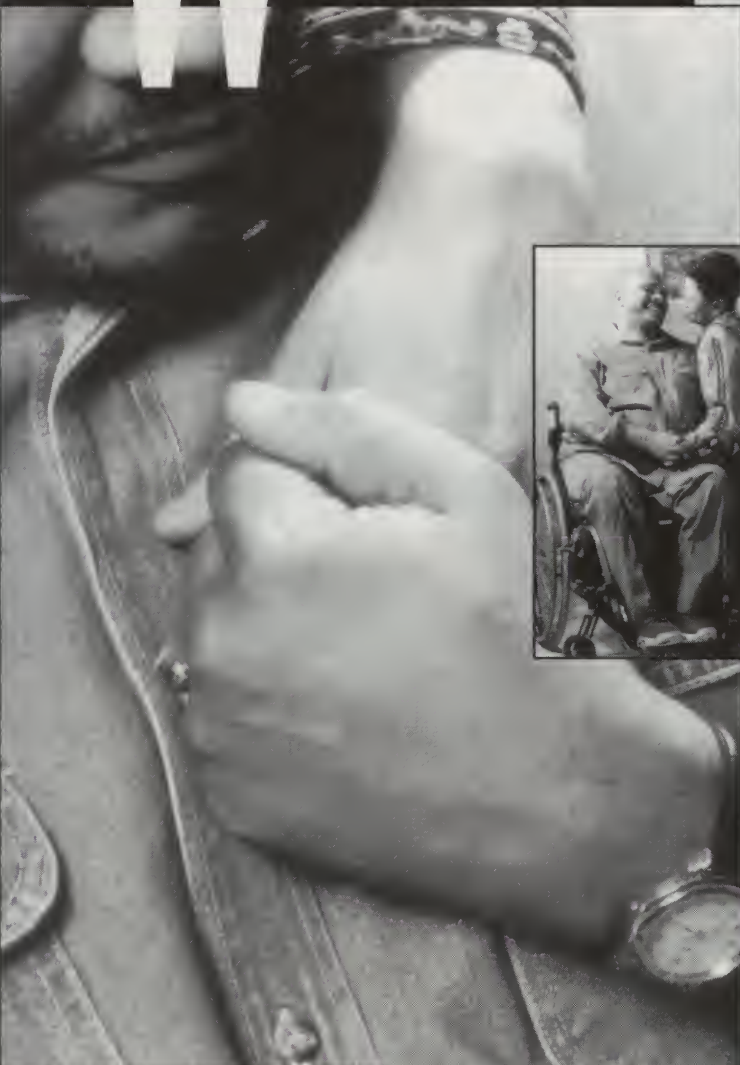
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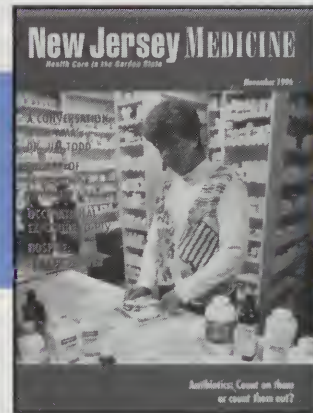
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Jill M. Brzezynski, RP, owner of the Cranbury Pharmacy, has seen a steady increase in prescriptions for antibiotics. Writers Bill Berlin and Karin Gillespie explore whether the days of antibiotics are numbered. Cover: Conrad Gloos



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# New Jersey MEDICINE

## Certificate of need

The Newswatch section in the August issue of *New Jersey MEDICINE* contains a brief article in which advocates of new health facility construction complain of a "glacial" pace in certificate of need (CN) decisions at the Department of Health and Senior Services (DHSS). When I became commissioner of health, I made speeding the CN process a priority. As you will see, we've made good on that promise.

We've overhauled our expedited review process, adding new services and making the application process easier so that the health care facilities may more flexibly respond to the marketplace. DHSS operates under a 90-day deadline for issuing decisions under expedited review. Since the program took effect in April, we've decided 167 CN applications. All these decisions were issued within 90 days of when the applications arrived in Trenton. We've also added to the menu of services available under expedited review, such as assisted living, comprehensive personal care, ambulatory care, MRI basic obstetrics, and outpatient rehabilitation.

For CNs that require full review, we've imposed strict deadlines on ourselves. These

deadlines underscore our commitment to speeding the decision-making process so that health care facilities can be more flexible competitors. Under our new rules, CNs requiring full review have to be made within four months when there are 20 or fewer applications. In batches of more than 20, decisions must be made within six months. We are constantly revisiting our CN process to ensure that it's adaptable to a more competitive environment.

For the first time, we have a system of tracking CNs through a monthly status report. Interested parties can see their applications progress by checking the monthly status report.

As you can see, we've made good on the promise to speed the review process. DHSS is more accountable than ever before because we operate under deadlines and inform the public of our progress through monthly status reports.

*Len Fishman, Commissioner*

## Medical marriages

The book, *The Medical Marriage. A Couple's Survival Guide*, is of value to young couples who have not experienced the stress of the new physician's backlog of debt once medical training is com-

pleted, the never-ending difficulty of leaving work behind at the end of the day, doctor bashing, and malpractice. Young couples soon learn the surprise that rather than having one job, most physicians have to be clinicians, consultants, teachers, and medical politicians. Among the most common crises faced by medical couples are the conflicts over child rearing, midlife questioning, extramarital affairs, career transition, malpractice stress syndrome, and financial problems. The authors, Wayne M. Sotile, PhD, and Mary O. Sotile, MA, maintain the way you manage yourself during these crucial passages determines whether your marriage endures as "your most profound source of strength and support or the most annoying source of stress."

The authors offer their advice: Respond to the underlying need, rather than the expressed behavior; avoid the trap of managing stress, and don't believe your partner's stress is more important than your stress; soothe each other; and be a unique source of intimate connection for each other. Increased intimacy is the most powerful defense against the adverse effects of the stresses of medical life. This is good advice but I would like to add the need to learn to



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*Susan Kahn, MSNJ  
President-Elect*

## *Needle exchange*

Reading the August issue, I was thrilled to encounter Dr. Slobodien's courageous support of the use of needle exchange for drug addicts as a measure to combat HIV, and his editorial recognition of HIV and AIDS as public health menaces. In a subsequent article, however, I was appalled to discover that the MSNJ Council on Public Health considers mandatory testing for HIV inappropriate, this after describing it as "a pandemic infection that must be brought under control," and that this report was adopted by MSNJ.

Without mandatory testing there can be no control. Currently, mothers at term can refuse to be tested thus putting their newborns at risk since postpartum treatment is effective. I don't believe that MSNJ wants to accept responsibility for those untreated infants.

In addition, HIV leads to AIDS, a condition that confers all sorts of opportunistic infections on the victim, including antibiotic-resistant tuberculosis. Short of identifying HIV positive patients and checking them periodically for a descent to the hell of AIDS, we are permitting them to mingle

anonymously with their family and friends putting them at risk for the secondary contagions of AIDS.

Individuals with HIV require periodic medical scrutiny, and the epidemic requires intense surveillance.

The public cannot be protected unless HIV carriers are identified and required to undergo periodic blood work and chest x-rays at the very least. No plague can be contained unless its sources are monitored.

MSNJ knows this. What rationalization permits consideration for the individual to take precedence over consideration for those at risk from the secondary effects of HIV/AIDS?

*Charles Harris, MD*

## *What do optometrists want?*

I wish to comment on Dr. Donald Cinotti's article concerning the ambition of optometrists to begin using laser therapy even though it is a surgical procedure. Not only are the optometrists keying up to perform laser procedures but they are planning to practice medicine without having to spend the time to properly assimilate all the knowledge required. This can be plainly seen by the recent articles in the *Review of Optometry* discussing the treatment of systemic hypertension, the proper

manner for performing venipuncture for intravenous medications, and intramuscular medications.


It becomes obvious that the optometrists not only wish to practice ophthalmology but they are intent upon practicing medicine with the privileges granted by legislators and avoiding the lengthy tried and true method physicians have undergone. Remember, that optometrists have no requirements for postgraduate training and they compare themselves to dental graduates who perform medical procedures with no postgraduate requirements as well.

Optometric graduates, OD, or "other doctors" are paramedical personnel who are not trained to make medical decisions. Medical decisions and judgment require a medical mind and the only route is a trip through medical school, internship, and residency. There are no shortcuts. At this time, the only postgraduate training that seems obvious for ODs is the lobbying of legislators.

All of this leads up to the fact that all physicians must coordinate their efforts to prevent the incursion into medicine of inadequately trained individuals who pass themselves off to legislators that are easily influenced by financially supportive ODs.

*Marvin G. Frank, MD*

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James J.  
Doyle, Jr

## Chilton Memorial honored with accreditation distinction

**Chilton Memorial Hospital**, in Pompton Plains, received a perfect score of 100 from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the nation's oldest and largest accrediting body. Chilton was the first hospital in the Garden State to receive a perfect score and is among less than 1 percent of hospitals in the United States claiming this distinction. The hospital was awarded accreditation with commendation, the highest level of accreditation. James J. Doyle, Jr is Chilton's president and CEO.



Paul W.  
Armstrong

## American health and law award

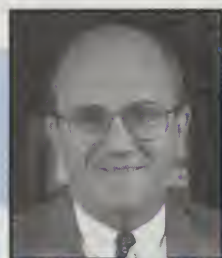
**Paul W. Armstrong, JD, LLM**, was honored with the 1996 American Health and Law Award at ceremonies in Martinsville. The award was given on behalf of the Watchung Area Council Boy Scouts of America. Mr. Armstrong is a member of the *New Jersey MEDICINE* Review Board and a consultant to the MSNJ Committee on Biomedical Ethics. Department of Health and Senior Services Commissioner Len Fishman and Paul R. Langevin, Jr, served as dinner co-chairs and Leonard Bielory, MD, served as event coordinator.

## November is national hospice month

"Hospice: A Photographic Inquiry," is the subject of an exhibit at The Morris Museum in Morristown from January 5, 1997, to February 23, 1997. The exhibit features the work of outstanding American photographers and a documentary film, and was organized by The Morris Museum in collaboration with the National Hospice Foundation and the Corcoran Gallery of Art. The Morris Museum is located at 8 Normandy Heights Road, Morristown, 201/538-0454.

## Exploring the changes in health care

MSNJ executive director, Vincent A. Maressa, JD, is slated to be a panelist at the November 15, 1996, conference, **New Jersey Health Care in Transition: Facing New Challenges, Learning New Skills**. The conference, sponsored by Rider University in Lawrenceville, will explore recent and future changes in the health care system and how they impact providers, health care producers, and community-based organizations. For registration information, call 609/219-2121.



Vincent A.  
Maressa

## Cancer prevention and control

New legislation strengthens the New Jersey State Cancer Registry as a tool to be used in cancer prevention and control. With the new bill, physicians must report all nonhospitalized cancer patients diagnosed and/or treated in offices. The

Department of Health and Senior Services (DHSS) anticipates an increase in reporting from nonhospital locations as more cancer patients are diagnosed and treated in physician offices. The new law includes penalties for nonreporting and DHSS encourages physicians to work closely with a hospital

tumor registrar to facilitate reporting of nonhospitalized cases. DHSS is drafting rules to support this new legislation. Any comments should be directed to Susan VanLoon, program manager, Cancer Registry, CN 369, Trenton, NJ 08625-0369.

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## New faces in the workplace

Monmouth Medical Center, Long Branch, has named **David J. Wallace, MD**, chair of the department of obstetrics and gynecology, a post he has held in an acting capacity for several years. A specialist in maternal/fetal medicine, Dr. Wallace practices in Long Branch. Dr. Wallace also serves on the hospital's Board of Trustees and is vice-president of the hospital's medical and dental staff.



David J. Wallace, MD



Julia Bakshiyev, MD

Two physicians joined the staff at Newark Beth Israel Medical Center. **Julia Bakshiyev, MD**, is affiliated with Beth Prime Care, which provides comprehensive primary care to local neighborhood families. **Makilzhan Shnmugam, MD**, has joined the Cardiac Transplant team.



Makilzhan Shnmugam, MD

**Stacey Singer** has been promoted to executive vice-president at CommonHealth USA, a health care communi-

cations and marketing resource headquartered in Parsippany. In this appointment Singer will manage the finance, information, technology, human resources, operations, consulting, and direct marketing.



Stacey Singer

**Dr. Thomas A. Cavalieri** and **Dr. Gary N. McAbee** have teamed with UMDNJ-School of Osteopathic Medicine, in Stratford. Dr. Cavalieri, a nationally recognized geriatric medicine specialist, has been named chair of the Department of Medicine. Dr. McAbee, a pediatric neurologist, has been named chair of the Department of Pediatrics.

**Joanne Coderre, RN, CNN**, received the Excellence in Clinical Practice Award from the Garden State Chapter of the American Nephrology Nurses' Association. Coderre has been a nephrology nurse at Raritan Bay Medical Center, in Perth Amboy, for 19 years.



Charles P. Vialotti, MD

Radiation oncologist **Charles P. Vialotti, MD**, has joined the staff of Pas-saic Beth Israel Hospital. Dr. Vialotti is a member of MSNJ's Bergen County component.

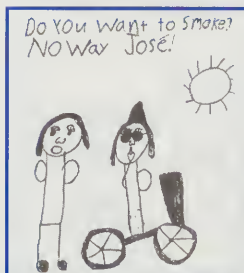
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2. Recognize your own humanity and your own human needs.
3. Control your practice. Do not let your practice control you.
4. Plan your free time as carefully as you plan your practice time.
5. Schedule adequate vacation time during the year. Break it up. One week every three months will recharge your batteries and keep medicine fun.
6. Recognize the needs of your spouse and your family for your time and attention.
7. Taking your own child to the doctor may be more important than scrubbing with the chief.
8. Never examine a female patient without a chaperone present.
9. Dedicate time to keep up to date—but not vacation time.
10. Prepare for retirement.



David I. Canavan, MD

**David I. Canavan, MD**  
Medical Director,  
Physicians' Health  
Program, MSNJ



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### Don't fool with Mother Nature

The modern age of antibiotics began in 1928 when Alexander Fleming noted the prevention of growth of *Staphylococcus aureus* by a contaminant airborne mold, *Penicillium notatum*. The newly labeled penicillin was used effectively by Chain and Florey in 1941 to treat osteomyelitis in a policeman, but the supply was limited. The United States, in a protected wartime location, then became the primary source of the new medication. Dubos, Waksman and Schatz, and many others in this country pioneered further advances.

Antibiotics are derived from living agents, bacteria or molds, that kill or inhibit microorganisms. (Synthetic "antibiotics" are properly called antimicrobials.) These actions have been known for millennia; the use of molds and other substances to treat wounds and infections having been reported from ancient civilizations. But it took Roberts, in 1874, and then Pasteur and Joubert, to note the antagonism of fungi and molds to bacteria and to suggest a possible clinical use.

The explosion of new antibiotics and antimicrobials in the 1960s, coupled with innovative and more powerful vaccines, heralded the age of "miracle drugs" that would eradicate infectious diseases forever. The penicillins and their successors became the bestsellers in the pharmacopoeia.

Then came the rude awakening. Deaths from infections escalated, due in large part to

the development of resistance, and newer maladies have emerged. The Centers for Disease Control and Prevention (CDC) estimates the annual cost of antibiotic resistance in the United States to be \$30 billion. The monies available from government have not kept pace with the needs. The production of new drugs has languished.

The articles by Berlin and Gillespie in this

issue of *New Jersey MEDICINE* outline most cogently the problems we face. Berlin reviews the discovery and use of antibiotics, shows the evolving problem of resistance, enumerates some of the causes of this problem, and suggests a rather dim view of the future. Gillespie augments the listed causes and suggests potential remedies.

Additional factors that may add to the sharp rise in infectious diseases include: changes in human activities, e.g. sexual practices, crowding, poverty, travel to isolated areas with exposure to animal vectors. The

mutation of infectious agents or the transfer of resistance genes (resistance transfer factors) from other bacteria also are of importance. This may be the reason that mutants, ordinarily of limited viability, can thrive in hospital environments when the resident bacterial population is under antibiotic siege, and why DNA plasmids containing the resistance trans-



Howard D. Slobodien, MD

*The evolving problem of resistance to antibiotics demands careful study. How can we overcome this critical situation?*



*We are living now, not in the delicious intoxication induced by the early successes of science, but in a rather grisly morning-after, when it has become apparent that what triumph science has done hitherto is to improve the means for achieving unimproved or actually deteriorated ends.*

Aldous Huxley, *Ends and Means*, 1937

*The "control of nature" is a phrase conceived in arrogance, born of the Neanderthal age of biology and the convenience of man.*

Rachel Carson, *The Silent Spring*, 1962

fer factors can replicate and turn innocuous bacteria into armored warriors. Natural selection makes a difference. And whence came prions?

Louis Lasagna, native of New Brunswick, wrote in the preface to his 1980 book, *Controversies in Therapeutics*, "A wise physician once said that doctors have to learn to live with ambiguity. . . . A good course in therapeutics could certainly be organized around the opposing positions taken by men of good will and expertise." Philip B. Lee, professor of social medicine at the University of California, San Francisco, opined that America is an over-medicated society. He felt anti-infectives continued to be used inappropriately and unjustifiably, despite the undermedication of those with chronic illness or severe pain. He underscored the need for hard data.

John P. Morgan, from the School of Biomedical Education, City College of New York, commented, "We do not comprehend the wide use of drugs by patients and physicians. We do not know much about the reasons for drug use that differ from our usual 'clinical' motives," and we did not understand the cultural context of drug use. He agreed, "There is still much wrong with American prescribing habits. Some of what is wrong relates to our inability to view and to analyze the social context of drug use without recourse to the clinical ruse. Other problems include timidity, underprescribing, a costly Puritanical approach to needed therapy, and, in some instances (and only some), overprescribing." (Will managed care effect a cure?)

Much has been made of the inappropriate use of antibiotics for the common cold. Dr.

Lasagna initiated a series of letters and articles on this subject in 1976 in the *Medical Tribune*, eliciting a tremendous response. Most seem to support his position—that patients seeking care were suffering a complication requiring treatment of secondary invaders. However, the use of "decision-trees" could refine the diagnoses and treatment options.

What are we to do? How much has changed since 1980? The solutions given by Gillespie are useful. We also can send public health workers to monitor compliance with needed antituberculosis medication, but I do not know how we can monitor commonplace patient self-prescribing, even in the face of more tightly controlled over-the-counter drugs. How do you insure that the prescribed number of doses is used and taken during the proper time frame? How do you keep people from taking leftover antibiotics for minor complaints or from giving them to friends? How do we finally convince Americans that antibiotics do not help the common cold?

Will it help to increase the average patient's knowledge of prescribed medications? If so, the law signed by President Clinton in August 1996 might prove worthwhile. It directs a large number of interested groups, including the AMA, to formulate and develop Medguides, under the auspices of HHS. The guides would apply to 75 percent of prescriptions by 2000 and 95 percent by 2006, and the FDA wants the information to include purposes, risks, indications, contraindications, and unwanted effects. The groups have until early December to reach agreement. We wish them well.

**NJM**

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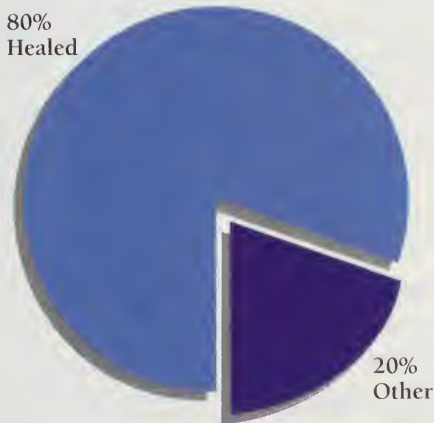
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## INTERVIEW WITH JAMES S. TODD, MD

**Dr. Todd recently retired as the executive vice-president of the AMA. A Ridgewood resident, Dr. Todd is a member of MSNJ and of the Bergen County Medical Society. He has served with the AMA since 1985 as senior deputy executive vice-president, member of the Board of Trustees, and commissioner to JCAHO. At the state level, Dr. Todd was a trustee and chair of the MSNJ Board of Trustees and chair of the New Jersey Delegation to the AMA House of Delegates. Dr. Todd was honored with the Edward J. Ill Award by The Academy of Medicine of New Jersey and the Distinguished Service Award by the New Jersey Hospital Association.**

**Q.** Why are we still seeing a steady increase in the number of Americans without health insurance?

**A.** The American Hospital Association estimates that that number of uninsured people will grow from 40 million to 47 million in the upcoming year, and employers in increasing numbers are not providing insurance to their workers. I don't think anything is going to happen unless there is a crisis. People are being taken care of, but in the most expensive fashion—after they get sick.

**Q.** Taking into account your own experience as a physician and a policymaker, how would you assess the state of the medical profession today?

**A.** The medical profession is in a very difficult and transitional stage. The American public has decided that it likes competition as a way of reducing health care expenditures. But competition is amoral: It doesn't care about the individual, it only cares about who wins and who loses. Because these

insurance companies can buy and sell patients, they can exert considerable pressure on physicians. Physicians find themselves dealing with 15 to 30 different contracts, trying to figure out which patients have which benefits, and there is a great deal of frustration within the profession.

**Q.** For many physicians, there seems to be a kind of culture shock at having to deal with a world for which they were not prepared.

**A.** That's true. For the first time, physicians are being asked to look at the dollars along with the treatments they give. Neither they nor the patients are controlling the dollars, and they're suddenly involved with a massive bureaucracy. At the same time, it is the physician who is expecting to be accountable for the quality of care provided when that care may be dictated by a 1-800 control number.



## *The medical profession is in a very difficult and transitional stage. The public likes competition as a way of reducing health care expenditures.*

**Q.** One of the major changes is in the traditional autonomy and authority physicians have possessed. How difficult is this for some physicians?

**A.** Well, it's even worse than that. There's a total hassle factor: Getting permission to provide the treatment, then trying to keep up with the almost infinite number of contracts physicians have, then trying to run an office. This is going to push an increasing number of physicians into groups to gain the economies of scale, which only a group can provide.

We've got three groups of physicians today: Those that are at the upper end who will bear with it a few more years and then retire; a middle group that is trying to make the adjustments; and the students coming out of medical school who are not well-prepared for this new world but understand the concept of salaried physicians and managed care. And some of

them may actually prefer the predictable hours and income that comes with the new medicine.

**Q.** You've said that you see a pendulum in terms of the way the profession is responding to managed care. What do you mean by that?



James S. Todd, MD

**A.** As I said, I think we're going through a nasty shake-out phase at the moment, and we're way up on the pendulum swing toward cost-reduction and control over the physician. But it's important to differentiate the two types of managed care. One is the Mayo Clinic, Kaiser-Permanent not-for-profit model, which

involves doctors in a very collegial fashion so they are careful to ensure that they are providing the best care. Then there is the investor-owned managed care programs whose apparent sole purpose is to reward investors. And when you are trying to make money by reducing the amount of health care you're giving, there comes a time when you just can't reduce costs anymore. At that point, what are the for-profits going to do? They will lose investors, the companies will try to find more fertile ground, and hopefully, the medical profession will have put together adequate mechanisms to pick up the slack. Short of that, if the whole system collapses, the only alternative would be a government takeover.

**Q.** We do seem to be getting inklings, if you read the medical journals and newsletters, that some physicians are getting so fed up that they would even prefer more government control.

**A.** A recent poll in California found that 49 percent of the physicians would opt for a single-payer system. Instead of having 20 or 30 different contracts, you'd have just one place to send the bill. It's totally predictable, and a single-payer system might prove to be more generous, if Medicare is any guide.

**Q.** Speaking of the future, what are your thoughts about where we are heading in terms of graduate medical education?

**A.** I'm concerned about the whole continuum of medical education as we look to the future. The mark of an educated person is not going to be what they know, but do they know where to find it in a timely fashion. If you look at the residency programs, they still are predominantly in the hospitals, which have become tertiary care centers. The residents are seeing the most complicated of cases, but they are not getting into the ambulatory clinics, into doctor's offices, and into the day-to-day practice of medicine.

For its part, continuing medical education is a vast wasteland where trying to find a good series of programs to keep yourself up-to-date in your specialty is very difficult. I should also mention that in the future, physicians probably will be less likely to have the time or the resources to travel around the country to meetings. Electronic education—through interactive CD-ROMs and the Internet—probably will become more important.

**Q.** This brings up another issue that is affecting more than the world of medicine—the tremendous explosion of knowledge today. Logic says that this would lead to more specialization, but economic factors seem to be leading to more emphasis on generalists through primary care.

**A.** All you have to do is read the medical journals or newspapers and see how rapidly the new advances are occurring. Clearly, if physicians are going to work in a highly technical field, they are going to have to specialize. No one physician can know it all today, and

that's one of the dangers of the gatekeeper in some of the managed care programs. I like to call them "which doctors"—that is, "To which specialists should I refer the patient?" That's going to increase the primary care physician's liability through failure to diagnose, misdiagnosis, failure to refer, or negligent referral.

**Q.** What advice would you give new physicians today?

**A.** I'd tell them to remember why they went to medical school in the first place. I'd tell them not to be deterred by all of the distractions and pick and choose carefully in terms of specialty and practice mode. We did an interesting survey a few years ago of young physicians who either were in the first 5 years of practice or under the age of 40 years. We asked them what they wanted most out of their profession. The basic answer was: balanced lifestyles. I think physicians see the intensity of what is happening to the profession, and they want to have some predictability of hours and the ability to be spouses, parents, and citizens.



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## Antibiotics with an attitude: Are they working?

Bill Berlin, PhD

Once the heavyweights in the pharmaceutical arsenal, antibiotics are losing some of their punch in the face of emerging and re-emerging pathogens and drug-resistant bacteria.

The development of antibiotics dates back to the historic research of Louis Pasteur and Paul Ehrlich who discovered that one type of microorganism can kill another. In the 20th century, the discovery of penicillin in 1928 and streptomycin in 1944 launched a period of remarkable discovery, with the creation of new antibiotics from bacteria and molds found in all parts of the world.

Since the 1940s, researchers have produced roughly 160 antibiotics from 16 basic compounds, including tetracyclines, cephalosporins, quinolones, and

polymyxins. These drugs were so effective in dealing with infectious diseases that in the last 30 years, thousands of chemicals identified as likely candidates for antibiotics were rejected for retail development. Little wonder, then, that Dr. Linda Hawes Cleaver, editor of the *Western Journal of Medicine*, has be-

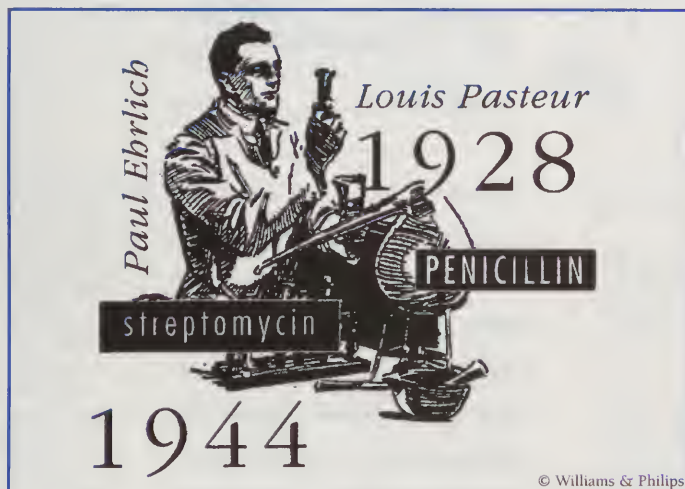
1973, researchers have identified 30 previously unknown infectious diseases, such as AIDS, Legionnaire's disease, Hantavirus, pulmonary syndrome, and Ebola hemorrhagic fever. Moreover, the incidence of antibiotic-resistant strains of such "older" diseases as pneumonia and tuberculosis is growing rapidly. Consider the following trends:

- Between 1989 and 1993, there was a 20-fold increase in hospital-acquired vancomycin-resistant enterococcus, which one expert has dubbed "the pathogen of the 1990s."

- In 1992, 13,300 U.S. hospital patients died of bacterial infections that did not respond to prescribed antibiotics.

moaned our approach to infectious disease control as one of "arrogant optimism."

Today, apprehension has replaced arrogance as infectious disease mortality in the United States increased by 39 percent between 1980 and 1992. Since



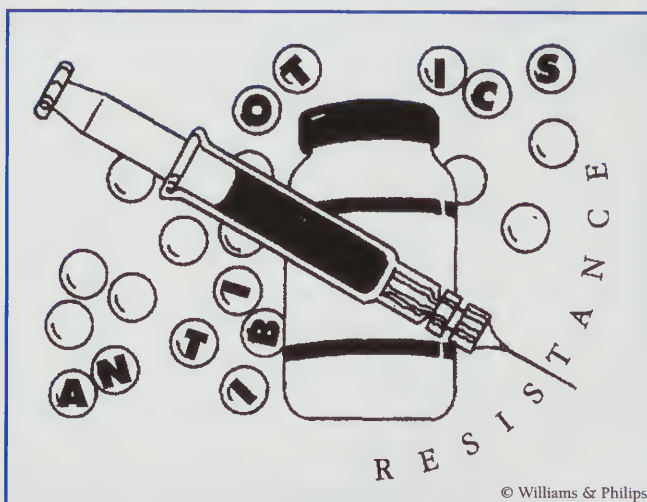


- *Staphylococcus aureus*, associated with blood infections, surgical wound infections, pneumonia, and heart valve infections, is becoming increasingly resistant to antibiotic treatment.
- Drug-resistant pneumococci infections jumped 150 percent between 1987 and 1994.
- The National Foundation for Infectious Diseases estimates that the annual cost of hospital-acquired infections is \$5 billion, much of which is due to the fact that 70 percent of nosocomial infectious agents are drug-resistant.

Other forms of infection, from acne to bronchitis, are showing greater resistance to traditional drug therapies. For some health care professionals, the most immediate and personal concern is the emergence of drug-resistant pulmonary tuberculosis, often associated with HIV-infected patients treated in hospitals. "The frequency of infections with *M. tuberculosis* resistant to

anti-tuberculosis drugs is increasing in the United States and globally," warns Dr. Michael Iseman of the National Jewish Center for Immunology and Respiratory Medicine.

The rise in drug-resistant infectious disease has generated



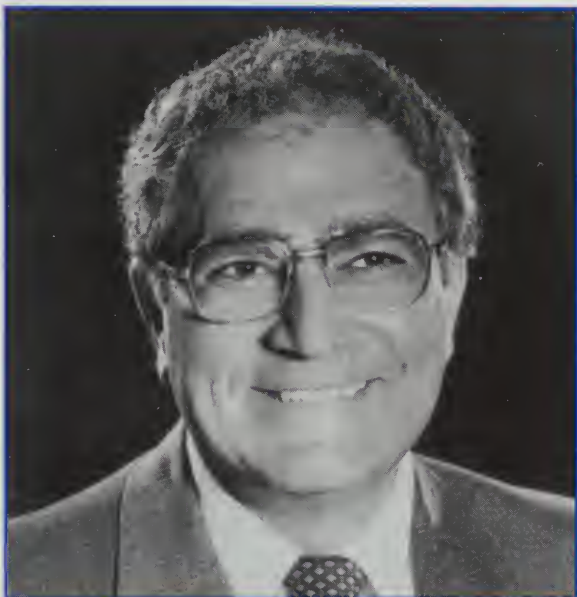
mounting professional attention and alarm. In January 1995, the editors of 34 medical journals agreed to highlight the global threat of infectious disease by publishing more than 200 papers and editorials focusing on emerging and re-emerging pathogens. Just two weeks later, Dr. Calvin Kunin of Ohio State University warned a seminar at the University of California, San Francisco, that "the current situation is bleak. It will undoubtedly get worse as the burden of resistant organisms increases."

At a time when medical breakthroughs often seem commonplace, how can we explain the return of old enemies, such as tuberculosis, and the emergence of seemingly new diseases, such as AIDS?

The answers are complex, but the crux of the problem lies in the perpetual struggle waged by bacteria to resist and outsmart antibiotic foes. An antibiotic stops an infection by destroying an organism's cell wall, by inhibiting cell reproduction, or by suppressing creation of necessary proteins.

However, over time, some organisms have mutated so successfully that they now are invulnerable to antibiotic assault. Certain bacteria, such as *E. coli*, can expel the antibiotic from the targeted cells. Others can produce enzymes that destroy antibiotics before they attack. In some cases, what may appear to be a "new" disease may be an "old" pathogen that finds a new host or a new manifestation.

The overuse of antibiotics also has lessened their effectiveness, often providing opportunities for



*Leon Smith, MD*

drug-resistant bacteria to develop. Succumbing to patient pressure, many physicians have overprescribed drugs in cases where alternate treatments would suffice. "There's enormous pressure to use them," says Leon Smith, MD, chief of Infectious Diseases, Saint Michael's Medical Center, and professor of Medicine and Public Health at UMDNJ-New Jersey Medical School. "Many physicians worry about the legal implications if a patient develops a problem because antibiotics have not been prescribed. So, when in doubt, they are likely to prescribe."

Patients who demand antibiotics do not necessarily use them

properly, a problem that encourages bacterial resistance. Some individuals stockpile drugs and take them carelessly when they experience sniffles or other symptoms. Finishing only part of a prescription may permit surviving bacteria to

reproduce and develop more resistant strains. Patient education, therefore, is a must, and even in an age of increasingly bureaucratic medicine, not impossible. "Pediatricians have shown that you can decrease misuse by educating patients," says John Middleton, MD, chair of the Department of Medicine, Raritan Bay Medical Center, and a specialist in infectious disease and internal medicine. Many people, Dr. Middleton believes, do not appreciate the risks associated with antibiotic resistance, as seeing it as a problem limited to hospital patients.

Health care economics also may exacerbate the problem by emphasizing cost-effective drug therapies that rely on a few basic

antibiotics. Some critics say that by stressing drug management strategies aimed at controlling costs, HMOs and hospitals limit physicians to a few inexpensive antibiotics that can rapidly develop resistance. Low dosing, with blood concentration of the antibiotic below the minimum inhibitory concentration for 80 percent of the time, also can produce resistance.

Studies have revealed widespread misuse of these drugs in the United States but more so in other parts of the world. In many third world countries, antibiotics are sold over-the-counter and pharmaceutical companies have aggressively pushed their availability. With a million air passengers crossing national borders daily, drug-resistant bacteria are easy stowaways, and infectious disease is almost impossible to isolate. Infectious disease causes one-third of all deaths worldwide, with consequences that underline the need for a global approach.

Even global warming may play a role. Climatic changes can lead to the growth in animal and insect populations, greater human migration across borders,

*continued on page 30*



## Antibiotic resistance: How did we get there?

There is general consensus within the medical community that some level of resistance is inherent to antibiotic use. Even with proper utilization, eventually the Darwinian nature of microbes wins out. The strong survive, and succeeding generations of microbes are virtually immune to a particular antimicrobial's presence.

A number of factors have exacerbated the resistance problem—and essentially aided and abetted microbes in their efforts to outpace antibiotics.

*Changing antibiotic utilization patterns.* Managed care organizations, drug manufacturers, physicians, and patients shape antibiotic utilization trends. The managed care organization formularies restrict the range of medications a physician may prescribe, and ultimately control the kinds and numbers of antibiotics used by their members. Kevin Cleary, clinical coordinator of drug usage and evaluation at Englewood Hospital laments that formularies result in

antibiotic prescribing patterns that are often “plan-driven rather than organism-driven.” Drug manufacturers, in their effort to capture a share of the \$23 billion antibiotics market and recoup the ten or more years and \$300 million that it



takes to bring a new drug to the market, may spend an inadequate amount of time explaining a medication's downside and how it fits into the vast arsenal of antibiotics already available. Some physicians may view the new antibiotic as an improvement on equally efficacious existing antibiotics, and their subsequent prescribing patterns will reflect this. For example, a number of physicians appear to favor the broad-spectrum antibiotics over the narrow-spectrum antibiotics in treating

infection. A study reported in the *Journal of the American Medical Association* on “Trends in Antimicrobial Drug Prescribing Among Office-Based Physicians in the U.S.” found that the more expensive, broader-spectrum antibiotics



were prescribed at increasing rates during the period 1980 through 1992 and the less expensive, narrower-spectrum antibiotics, like penicillin, were prescribed at decreasing rates.

Michael Doyle, MD, a family practice physician based in Neptune, remains an advocate for the narrow-spectrum antibiotics. “I am treating mostly community-based infections, and I find that 95 to 99 percent of the time the ‘old-fashioned’ antibiotics work just fine,” he commented. “In addition, these antibiotics have a good

safety profile and they are less expensive."

Dr. Allen Nichol, executive director of the New Jersey Pharmacists Association, likens the use of broad-spectrum antibiotics to treat common infections like otitis media and sinusitis to "dropping an atom bomb to obliterate a mound of ants."



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Patients affect antibiotic prescribing and utilization patterns as well. Anecdotal evidence suggests that patients self-prescribe with leftover antibiotics and often do not complete the full antibiotic therapy.

"Antibiotics are expensive, so patients are more likely to keep any leftovers and reuse them," explains Edith Micale, RP, immediate past-president of the New Jersey Board of Pharmacy. "Their perspective is, 'Well, I have some left and my sister is sick with the same

thing so I'll just share it with her.' The only way to combat this phenomenon is through patient education. Patients need to know that they must take all their medication and that they should not be self-prescribing or sharing medications with friends and relatives."

Patient expectations are part of the equation. A study



reported in the *Journal of Family Practice* found that a parental expectation that an antibiotic would be prescribed increased the likelihood of a diagnosis of bronchitis in children with a cough. The only finding more strongly correlated with a diagnosis of bronchitis was the presence of rales determined through a physical examination.

*Misconceptions about our control over infectious disease.* Infectious disease has been and still is the number one cause of death, outpacing both cancer

and cardiovascular disease. However, popular belief holds that "microbial threats to health (are) a thing of the past." According to the Institute of Medicine in Washington, DC, this confidence resulted in a general "complacency." As a result, mutating microbes gained a lot of ground after 1975 and continued to do so into the 1980s as the attention of the public health, research, and clinical communities shifted from acute, infectious disease to more chronic conditions. This complacency was echoed within the pharmaceutical industry; many of the leading drug manufacturers in both the United States and Japan cut back on their anti-infective R&D budgets, resulting in fewer new antibiotics in the pipeline.

*Mobility of the world's population.* In an age of inexpensive and accessible air travel, organisms know no geographic bounds. Because people can so readily move from country to country, an organism that develops resistance to antibiotics in Tanzania today may exist in Thailand tomorrow.

—Karin Gillespie



continued from page 27

and a rise in sea-surface temperatures and water levels—all of which can increase the transmission of infectious disease.

Prospects for the immediate future are not encouraging. About one-half of all drug companies closed shop on antibacterial research in the 1980s, before significant drug resistance began to emerge. While modern molecular tools, such as DNA and RNA sequencing, may lead to the discovery of new types of antibiotics, development and testing of these drugs will take at least 10 to 15 years.

Dr. George Miller of the Schering-Plough Research Institute told Congress earlier this year that developing new antibiotics will be a lengthy process, with seven out of eight drugs tested never reaching the mar-

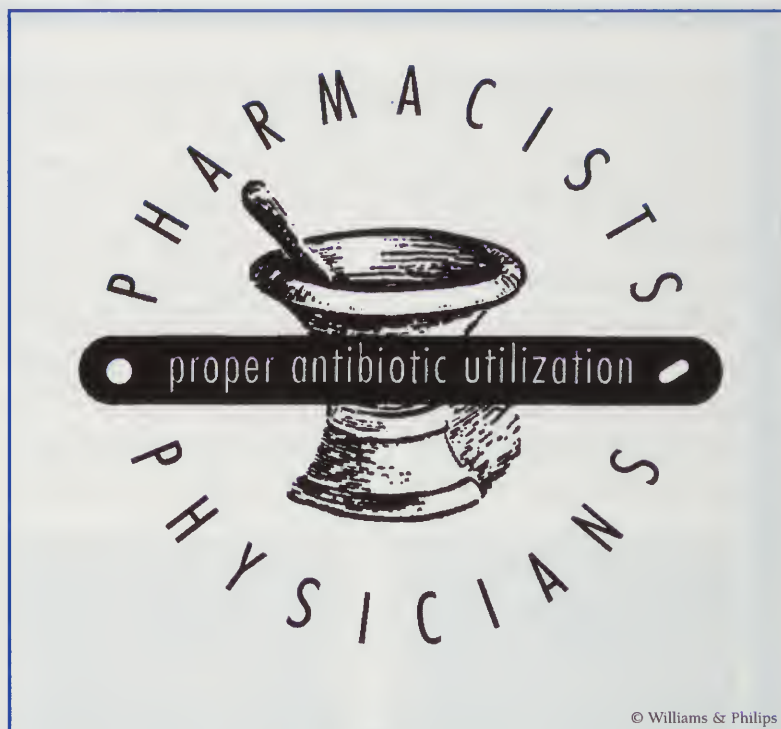
ketplace. And he added an important warning: “We’re going to introduce new antibiotics, but if we don’t change the way we use them, the problem will continue.”

There are several implications for physicians. A number of hospitals impose restrictions on antibiotic use, often requiring approval from an infectious disease specialist before they can be dispensed. More hospitals are likely to move in this direction, possibly employing consensus practice guidelines programmed into an institution’s infor-

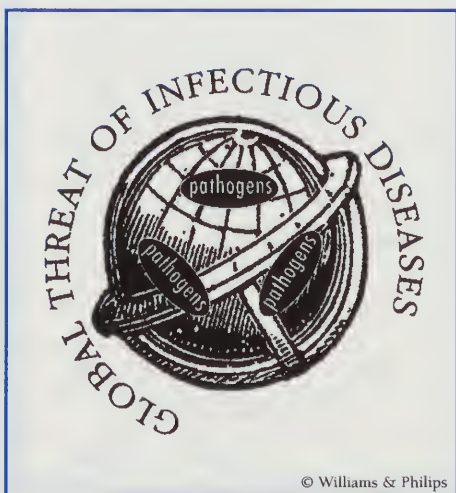
mation system as rules and algorithms. Some specialists now counsel cycling of antibiotics or using a few in combination to enhance effectiveness. Others foresee more emphasis on preventive health, strengthening the immune system, and patient education.

Clearly, there are no simple answers to this problem. Indeed, some observers worry that there may be no answers at all. As the population ages and as AIDS and other infectious diseases take their toll, the situation is likely to worsen. “I think by the year 2010,” Dr. Smith warns, “it’s going to be a major, major problem.”

**NJM**



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## Can we combat resistance?

What will it take to make strides against antibiotic resistance? It will take a concerted effort by the public health, research, and clinical communities. Some of the strategies that hold promise include:

- Increased surveillance efforts to identify and prevent the dissemination of drug-resistant organisms. Both the CDC and the Institute of Medicine stress the need for increased surveillance. According to the CDC, "The true magnitude of antimicrobial drug resistance is unknown because of the absence of systemic monitoring."
- Shorter courses of antibiotics, increased use of narrow-spectrum antibiotics to treat identified organisms, and decreased use of long-duration IV antibiotic therapy.
- Limited marketing of over-the-counter antibiotics.
- The development of community-based infection control and antibiotic utilization programs, similar to those that have been successful in hospitals.
- A shift of dollars back into antimicrobial R & D. Pharmaceutical companies already are making progress in this area, and they are doing it in partnership with biotech firms. For example, Pfizer is partnering with Microcide Pharmaceuticals of Mountain View, California, to identify genes essential to a microbe's survival and create a way to disable them to prevent a bacterium from developing.
- The creation of a "fast track" for antimicrobials in the pipeline so they are ready and available when needed. The Institute of Medicine stresses that "replacement drugs

need to be in the pipeline to counter both resistance and development of new organisms."

- Increased R&D capacity for developing vaccines for infectious diseases. Some researchers see vaccines as one option to counter resistance. Their rationale: if we can prevent the disease, we don't need to develop a treatment. Currently, both Wyeth and Merck pharmaceutical companies are developing a pneumococcal vaccine for children. This bacterium is the cause of pneumonia, ear infections, and meningitis, and frequently is resistant to penicillin.



*Edith Micale, RPh, agrees that physicians and pharmacists need to work together.*

Any and all efforts to combat resistance, cautions Dr. Harrison of the Institute of Medicine, should be orchestrated. "We need to see the beginnings of dialogue," Harrison stated. "For example, to have an effect on antibiotic prescribing practices, there must be concordance between the drug manufacturing industry and clinicians. The major HMOs also should be brought into the dialogue. And one can then hope that through the

force of competition the fruits of their conversation will trickle down to the smaller HMOs. And, certainly the media needs to be privy to this discussion."

Edith Micale, RPh, agrees that teamwork is needed at a global policy level—and at the more micro clinical level as well. "Physicians and pharmacists also need to work as a team when it comes to assuring proper antibiotic utilization," she notes. "Pharmacists need to re-emphasize with the patient what the physician has said about appropriate drug use. It's a constant educational process."

—Karin Gillespie





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## FIBROUS DYSPLASIA PRESENTING WITH PNEUMOCEPHALY

**Drs. Murphy, Glazier, and Nosko are affiliated with the Division of Neurosurgery, and Dr. Keller is affiliated with the Department of Radiology, Robert Wood Johnson University Hospital, New Brunswick.**

Pneumocephalus is a condition associated with trauma. Spontaneous pneumocephalus, however, also is a well-known clinical entity and various causes have been reported including neoplasms, surgery, infection, and congenital malformations. There have been no previous reports of pneumocephalus secondary to fibrous dysplasia. We report the first case of fibrous dysplasia of the frontal sinus presenting with spontaneous tension pneumocephalus.

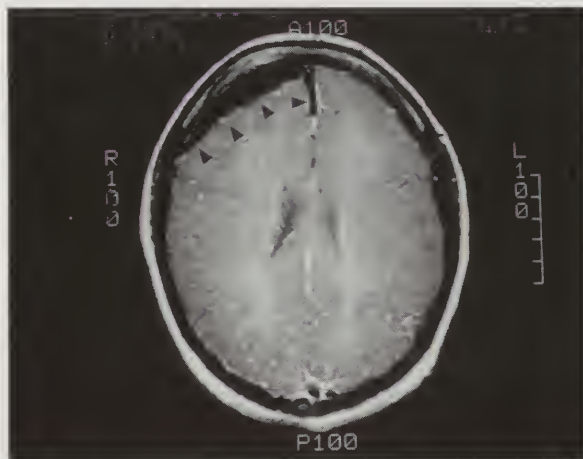
**Case history.** A 23-year-old female presented with a one-week history of right frontal headache and new onset of weakness and numbness in the left side of her body. She had

moderately diminished strength of the left lower extremity. The remainder of her neurological and physical examination was unremarkable.

Investigation revealed normal laboratory values. Magnetic resonance imaging (MRI) of the brain was obtained on an outpatient basis. A large right-sided, extra-axial mass was evident. It was hypointense on all sequences and had an interface concave toward the brain surface. Mild right to left shift of the midline indicators was evident (Figure 1). Phase contrast imaging was used to exclude an arteriovenous malformation, fistula, or dilated varix. Computerized tomography (CT) obtained immediately following the MRI con-

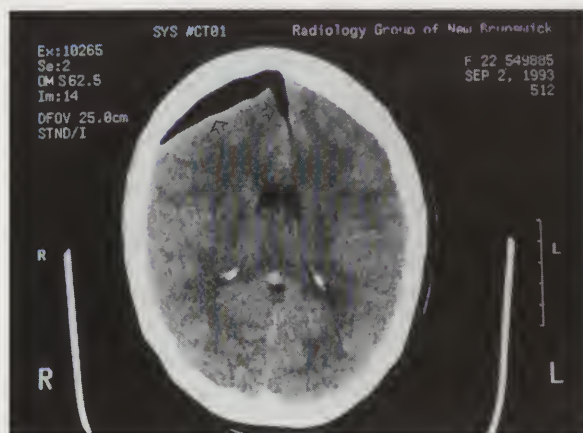
*David P. Murphy, MD  
David B. Glazier, MD  
Michael G. Nosko, MD, PhD  
Irwin A. Keller, MD*

firmed the presence of pneumocephalus and excluded hyperacute subdural hematoma, focal hyperostosis, and dural calcification/ossification (Figure 2). Complementary imaging findings from the MRI and CT scans demonstrated the presence of a small, heterogenous, partly calcified and partly enhancing mass along the back wall of the right frontal sinus (Figures 3A and 3B). The thinned posterior wall of the sinus with a cortical fracture angulated posteriorly toward the right frontal lobe surface confirmed the etiology



**Figure 1.** Axial T1W1 postgadolinium administration. Right frontal extra-axial gas extends into the anterior interhemispheric fissure (black arrowheads). There is minimal "bowing" of the anterior aspect of the falx cerebri.





**Figure 2.** NCCT at the level of the lateral ventricles confirms the presence of pneumocephalus (open black arrows).

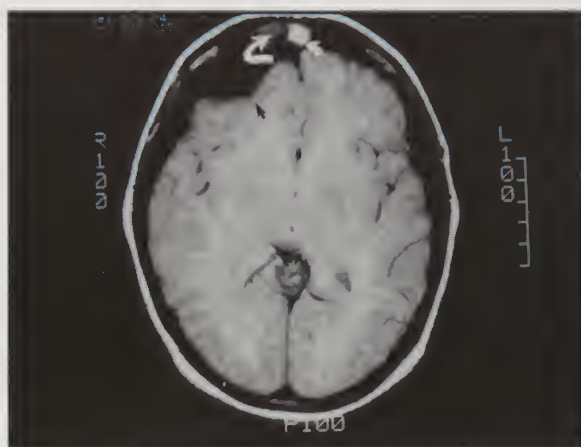
of the spontaneous pneumocephalus in this patient (Figure 4). The signal and density characteristics of the frontal sinus mass were consistent with the diagnosis of fibrous dysplasia (Figure 5).

The patient underwent a right frontal craniotomy with excision of tumor, exenteration of the right frontal sinus, and repair of a dural fistula. A 3 mm hole found in the dura was closed.

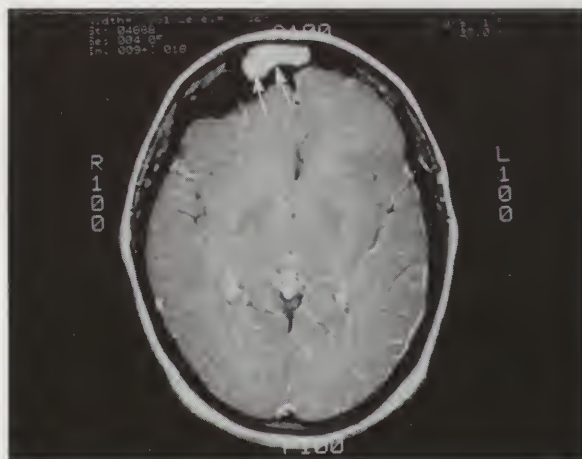
The final diagnosis was fibrous (fibro-osseous) dysplasia of bone. Fibrous dysplasia is a benign disorder of bone characterized by progressive replacement of a localized area of bone by an abnormal proliferation of fibrous tissue. It

occurs in both monostotic and polyostotic forms and in association with various clinical syndromes. The skull is involved in approximately 6 percent of cases. Lesions appear as areas of fibrous connective tissue with curvilinear trabeculae of woven bone said to resemble "Chinese letters."

Five months after surgery the patient underwent a followup MRI scan to evaluate complaints



**Figure 3A.** Axial T1W1 pregadolinium administration. Right-sided frontal sinus mass. Midline hyperintensity (short, curved white arrow) represents high signal mucus secondary to obstruction by the more peripheral, right-sided frontal sinus mass isointense to cancellous bone precontrast administration (large, curved white arrow). Note the presence of pneumocephalus (short, black arrow).



**Figure 3B.** Axial T1W1 postgadolinium administration shows enhancement of peripheral, right-sided frontal sinus mass (curved, white arrows).

of occasional frontal headaches. The examination was unremarkable, without tumor recurrence being noted. She remains well one year postoperatively.

**Discussion.** The presence of air within the cranial cavity has been recognized as a clinical entity since it was described at autopsy in 1884 and it was first observed radiographically in 1913 in a patient who recently had sustained head trauma.<sup>1,2</sup> It was based on these early observations that ventriculography and the pneumoencephalogram came into being as diagnostic tests for intracranial mass lesions.<sup>3</sup>

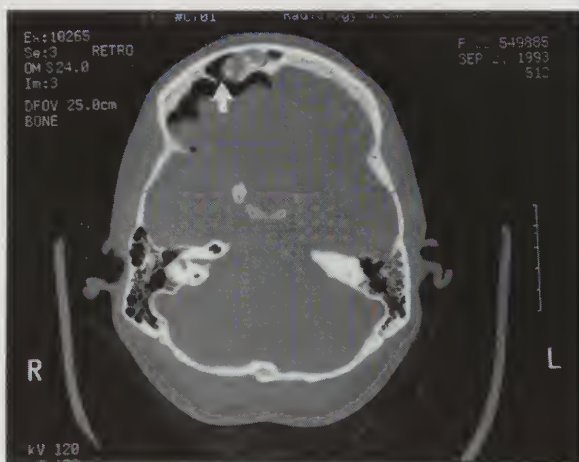
Pneumocephalus after head trauma has been described often in the literature.<sup>4</sup> Air entry into the cranial cavity during surgery also is well known.<sup>5,6</sup> Paranasal sinus surgery, posterior fossa surgery, and transphenoidal hypophysectomy all carry the risk of pneumocephaly. Other iatrogenic causes include complications of epidural anesthesia and nasogastric tube insertion.<sup>7,8</sup>

Pneumocephalus occurring without trauma or craniofacial surgery is very rare. Spontaneous pneumocephalus was first documented in 1927, and has since been described associated with neoplasms, infection, and congenital defects as

well as a complication of longstanding increased intracranial pressure.<sup>9-12</sup>

An osteoma involving the paranasal sinuses is the most common lesion associated with spontaneous pneumocephalus and has been well documented.<sup>13-15</sup> Pneumocephalus also has been associated with a frontal-ethmoid neuroilemmoma, pituitary adenoma, epidermoid tumor, and carcinoma of the maxillary sinus.<sup>17-19</sup>

On extensive literature review, there are no reported cases of pneumocephalus as the presenting feature of fibrous dysplasia, and no reports of spontaneous pneumocephalus imaged by MRI.



**Figure 4.** NCCT. Bone window images demonstrate the thinned posterior wall of the frontal sinus at the level of the mass with focal cortical fracture (thick, short white arrow) and pneumocephalus.



**Figure 5.** Coronal, NCCT. Right frontal sinus mass with mixed ossific and soft tissue density (short black arrows), strongly suggestive of fibrous dysplasia.

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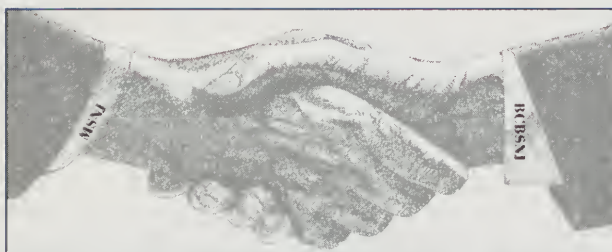
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## HOSPICE IN NEW JERSEY: 20 YEARS OF PROGRESS

*Dona Schneider, PhD, MPH  
Denyse L. Adler, MA  
Audrey Gotsch, DrPH, CHES*

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Hospice is a concept of care for the terminally ill that is adept at ameliorating physical pain and suffering, while maximizing spiritual and emotional comfort. Originally focused on cancer patients, hospice has expanded to provide care to others, especially those with AIDS and end-stage heart disease. Addressing the patient and family as the unit of care, hospice concerns itself with the issues of bereavement and the long-term impact of death and

dying on family members. In New Jersey today, more than 38 facilities provide skilled and compassionate hospice services for the dying.

The modern hospice movement emerged in the late 1960s and early 1970s, the period when western medicine expanded as never before, with new technology applied to intensive and cardiac care units, surgical techniques, and new treatment advances. The public came to expect medicine to cure, or at least to prevent death or disability from most diseases and conditions. When President Nixon signed the National Cancer Act in 1971, the media promised that the magic bullet was just around the corner. One result of these expectations was that physicians and health professionals came to view the death of a patient as a personal failure. Their feelings of helplessness and frustration often were translated into patient isolation. Terminally ill patients were placed at the end of the hall, frequently skipped on rounds, and denied the opportunity to

discuss their fears and concerns. Rarely were the true diagnosis and prognosis discussed, and communication between patient, staff, and family often ceased abruptly. Pain and symptom control were not priorities, and concerns about use of narcotics and the potential for addiction prevented physicians from prescribing adequate amounts of medication. The concepts of anticipatory grieving, family emotional health, and spiritual needs were low priorities for health professionals.

In Britain, Dr. Cicely Saunders began de-emphasizing curative medical care when appropriate, and began advocating a holistic approach to terminally ill cancer patients. St. Christopher's Hospice opened in London in 1967, emphasizing the family unit and flexibility in creating individualized programs. Although the British model was primarily inpatient in nature, the philosophy of the modern hospice movement was further developed in the United States, focusing on aiding the patient wishing to die at home.



*I called a meeting of the medical staff and they practically poo-pooed me. One said, "No, that's not what we do. We turn them over to a priest. If they're dying, they're dying." Zachary Morfogen*

A second event brought the discussion of death and dying out of the closet. In 1969, Elisabeth Kubler-Ross published *On Death and Dying*. Nurses especially, gravitated to Kubler-Ross's book, and the taboo of speaking about death was broken. In 1972, the U.S. Senate held hearings on death with dignity, including topics such as the right to die, the potential for living will legislation, the legal definition of death, and the hopes for a hospice care system in the United States. The groundwork for the modern hospice movement was firmly in place.<sup>1,2</sup>

*Growth of hospice in New Jersey.* The hospice movement in New Jersey emerged around 1974. One pivotal event was the visit of Zachary Morfogen, president of Riverside Hospital in Boonton, to St. Christopher's Hospice in London. Morfogen was so impressed by what he saw that upon his return he announced to his staff that Riverside Hospital would embark upon creating a hospice program. Members of his staff claim Morfogen was very persistent in his demands and, within that same year, a study committee for forming the hospice was created.

Simultaneously, other motivated individuals and institutions in the state became convinced that a better way of caring for the patient population was possible, and they began to develop their own models for the care of the terminally ill. At St. Elizabeth's Hospital in Elizabeth, the Reverend Charles Hudson and Peggy Coloney started an in-hospital program targeted for dying patients and their families in 1975.

That year also was important for the hospice movement, as the plight of Karen Ann Quinlan made headlines. The Quinlan family, with their attorney, Paul W. Armstrong, focused attention on the dying patient, and through a landmark state Supreme Court decision, New Jersey once again proved itself capable of setting the national agenda on the issue. The visibility of the process contributed to the establishment of the Quinlan Hospice program in 1979. Armstrong noted, "Karen literally became every woman. It was easy to empathize with her—and the rights, duties, and obligations of patients, physicians, families, institutions, processes, and procedures. But I think it also

underscored a deep flaw in how we provide care for terminally ill patients."

By 1976, Overlook Hospital in Summit responded to the need for more services for the dying by creating a home care-only hospice model, as a part of their existing home care agency. Perth Amboy Hospital and other hospitals followed this lead. Although hospice had gained a foothold in New Jersey with both the medical community and with the public, it was by no means universally accepted. Many physicians resisted the idea that patients could choose to terminate active treatment and considered hospice personnel intruders in the doctor-patient relationship. Many health professionals and families were reluctant to introduce the hospice concept to patients for fear of eliminating the patient's hope for cure. Attention to pain and symptom control methodologies was only beginning to gain the attention of scientists, and the ability to address pain without total sedation still was a long way off.

By 1977, interest in hospice had spread from coast to coast and that interest was not lost on

*Initially hospice was a spiritually driven mission felt by people in health care that recognized the abandonment people were experiencing as they were discharged from hospitals. Charles Hudson*

the federal government. NCI issued a request for proposals for three-year demonstration projects to field test the efficacy of the St. Christopher's model in the United States. One of the three successful competitors was Riverside Hospice in Boonton, which became one of the first freestanding hospices in the United States. The 13-bed facility, opened in June 1978, was used for backup and respite care, while 81 percent of all patient days were spent in the home setting.

Building on the demonstration project at Riverside Hospital, the first national training grant to prepare professionals and volunteers to care for the terminally ill was secured in 1978 from the National Institute for Mental Health by Dr. Audrey Gotsch. While there was a tremendous desire to support dying patients and their families, health care professionals as well as volunteers lacked the critical skills needed to address the many concerns that faced them as care providers in this new area of care. Over the next three years, training manuals and courses were developed to address how to prepare volunteers for

their work with dying patients and their significant others, how to address bereavement issues, and how to manage pain control. These training manuals continue to be the core of hospice training projects across the country, again demonstrating New Jersey's role as a significant leader in the hospice movement.

As a result of both the hospice training program and spreading public interest, additional hospice programs sprang up in New Jersey by the end of the decade. Muhlenberg Regional Medical Center Hospice in Plainfield, Samaritan Hospice in Moorestown, and Community Health and Nursing Services in Collingswood all began providing hospice services in 1979. With this increased interest by many institutions to implement hospice programs, the Hospice Training Project published *The Hospice Forum*, a newsletter to keep professionals updated about current issues facing health care professionals and volunteers caring for the terminally ill in hospice settings.

The key elements of hospice programs were developed during this period: pain and symptom control; the use of volun-

teers; and attention to bereavement. In other words, hospice acknowledged that the quality of time survived was at least as important as its quantity. Dedicated and trained volunteers augmented the medical care plan and provided companionship, support for families, and assistance with the concrete tasks of daily living. Often the volunteer made the difference between a dying patient remaining at home or requiring inpatient care. Bereavement services provided essential support necessary for family members to absorb their loss and to minimize health problems among survivors.

Originally, the hospice movement in the United States was a grassroots movement with a primarily spiritual base. As such, it was considered counter-cultural and often functioned outside of traditional health care institutions. In New Jersey, however, the early pioneers were mostly attached to established health institutions and were able to harness the resources of those institutions to develop comprehensive hospice programs. This does not mean that New Jersey programs faced fewer obstacles.



*We have patients that would rather sell the prescribed drug for pain than take it. We have the challenge of getting a homeless shelter to allow a person to stay until he dies. Clark Dingman*

Physician resistance, for example, remained strong. Many physicians felt that it never was appropriate to cease aggressive therapy. Both physicians and family members balked at the requirement that the patient understand that hospice was a program for the terminally ill. Local emergency squads and emergency room personnel would not accept the word of the family that the hospice patient wished no heroic measures. Instead, they insisted on utilizing all available technology. Nurses were not permitted to pronounce death on the scene, which then required the presence of the police or medical examiner, if the physician could not come to the home. Still other difficulties were financial—the programs often were totally dependent on donors or institutions willing to underwrite all of the costs.

With the proliferation of hospice projects throughout the state, the need for a statewide organization became apparent. On November 20, 1979, the New Jersey Hospice Organization (NJHO) was incorporated. The original trustees were Denyse L. Adler from Saint Barnabas Medical Cen-

ter, Paul W. Armstrong, Marilyn Thompson from Riverside Hospice, Shelley Van Kempen from Hackensack Medical Center, and Don Wernsing from Riverside Hospice, who served as the first president. In 1982, the William Lightfoot Shultz Foundation awarded the organization a grant that allowed NJHO to hire Maureen Eng as executive director. Shortly afterward, the Home Health Agency Assembly of New Jersey and the New Jersey Hospital Association offered NJHO secretarial support and office space at the Center for Health Affairs in Princeton. Today, the organization is located in Scotch Plains, with Don Pendley as executive director.

Many early hospice programs were initiated from within home health agencies, designating specific nurses as hospice nurses and building on the experience of the agency in caring for terminally ill patients at home. Others became part of the inpatient experience, and grew to accommodate patients following discharge. Others still, such as Hospice, Inc., of Glen Ridge, developed as consortium programs, in-

cluding several hospitals and providing services to a larger constituency. The face of the hospice movement changed on November 1, 1983, when the Department of Health and Human Services pronounced hospice to be an effective methodology for health care delivery and began the certification and reimbursement of hospice under Medicare. No longer a counter-culture movement, hospice was embraced by mainstream providers. Medicare, and ultimately Medicaid (as of November 1992), reimbursement provided the stability and resources necessary for hospice to further expand and flourish in the state. Today, there are few hospice programs functioning without Medicare certification. NJHO claims more than 38 Medicare-certified provider members and 26 associate (interested, nonprovider) members.

*The future of hospice programs.* A number of challenges face the hospice movement in New Jersey and across the nation. The accelerating movement to managed care, the complex needs of the AIDS and homeless populations, the

aging of the population, the downsizing of corporate America, the increase in the number of uninsured, and the threatened cuts in Medicare and Medicaid are only some of these challenges.

Managed care penetration in New Jersey, currently estimated at 30 percent, is anticipated to increase almost 70 percent by the end of the decade. Consequently, demonstrating cost effectiveness and negotiating with managed care insurers will increasingly become critical to the hospice movement, especially as more Medicare and Medicaid recipients move into managed care plans.<sup>3</sup> To address these changes, hospice service providers need to be integrated into the health care continuum rather than be viewed as an alternative to care. As cancer centers and other centers of excellence emerge, it will be important for them to include established hospice programs as part of vertically integrated health plans.

While competition generally is a positive element in the development of quality health care programs, the lack of a critical volume of patients can seriously hamper the ability of hospice programs to provide essential services. In many areas of New Jersey, several

programs currently serve the same catchment area, and it is probable that some will have to merge to survive. For-profit hospice programs also have begun to emerge in the state, and their ultimate impact is unclear at this time. Their development may have profound implications for how hospice programs meet the challenges of the next decade. Currently, any program can identify itself as a hospice, and if it does not



seek Medicare reimbursement, it can operate without meeting external standards. It is only a matter of time before accreditation for hospice programs becomes a reality.

Responding to rapidly evolving demands for health care includes the need for up-to-date and accurate data about experiences, outcomes, and costs. Unfortunately, acquiring these data requires a commitment of

technology, cooperation, and expertise generally absent in the hospice movement. As capitation may be in the future of hospice as well, documenting costs and benefits will be even more essential for hospice programs to successfully negotiate third-party payments.

Health care providers and the public must become more sophisticated about the benefits of hospice and what to expect from a program and how to determine the relative benefits of competitive programs. Hospice, for instance, provides skilled pain and symptom control, and a host of services not available in other settings. With early referral, hospice can initiate these services while there still is time for a balance of quality of care, and while the benefits of the program can be maximized; not just during the last few days of life. Patients may opt out of hospice benefits up to three times without losing benefits, so it is appropriate to consider referral when aggressive care is not currently appropriate, not only when it is terminated.<sup>3</sup>

The United States faces a rapidly growing cohort of older citizens who often have outlived their spouses and siblings, and may live great distances from children and other family



*We are beginning to see managed care directing families to hospice care when the family may not be ready. We need to remember it is still the patient's choice. Lorraine Sciara*

members. The traditional hospice movement focused on the individual who wished to remain at home to die, with a primary caretaker available to supervise the provision of services. This concept now is requiring significant revision as patients are increasingly homeless, uninsured, and/or the deinstitutionalized mentally ill. Indeed, providing hospice services to nontraditional populations continues to be an especially complex challenge. Many AIDS patients resist acceptance of hospice services as mortality from the disease often is from an opportunistic infection that might be successfully fought. For these patients, accepting the termination of aggressive care often is neither appropriate, nor welcomed.

Despite the changing face of hospice, its advocates continue to feel a strong commitment to the mission of the program to provide compassionate and skilled medical care for the terminally ill. No longer a middle-class suburban phenomenon, hospice faces the challenge of providing services to a younger and increasingly minority community.

**Conclusion.** New Jersey has been in the forefront of the development of hospice programs, and has provided many of the national leaders of the movement. The current challenge is to educate both physicians and the general population about the benefits of hospice care, and to appropriately integrate hospice services into managed care systems. We recommend physicians review *Standards of a Hospice Program of Care*<sup>5</sup> available from NJHO, become familiar with the hospice programs in their region, compare the services provided by these programs, and learn to discuss hospice openly with their patients in the same way they now do for advance directives.<sup>4</sup> These efforts will bring needed services not only to traditional hospice patients, but to those who now qualify and might have been overlooked in the past due to insurance, minority, or homeless status.

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## RECOMMENDATIONS FOR HIV OCCUPATIONAL EXPOSURE

**The authors are affiliated with the New Jersey Department of Health and Senior Services (DHSS), Trenton, where Dr. Paul serves as medical director, Division of AIDS Prevention and Control and Dr. Ziskin serves as deputy commissioner of health.**

Transmission of blood-borne pathogens is an occupational hazard for health care workers. An estimated 500,000 to 1,000,000 needle stick injuries occur each year. An estimated 1 percent of these injuries may involve a source patient who is HIV infected. Nationally, as of December 31, 1995, 49 health care workers have become HIV infected as a result of an occupational exposure. Twenty-two of these workers have developed AIDS.<sup>1</sup>

Workplace safety includes incorporation of infection control precautions, currently known as standard precautions, into daily practice to prevent exposure to blood. These

precautions include the appropriate use of personal protective equipment, i.e. gloves, eye protection, gowns, when contact with blood and other body fluids is anticipated. Needle stick and other sharps injuries may be prevented by changes in technique that help eliminate the need for needles/sharps and/or by the use of safer devices. Needles should not be bent, recapped, or broken. Needles/sharps should be placed in a puncture-resistant container to minimize the risk of exposure.<sup>2,3</sup>

Employers need to provide health care workers with a system for prompt evaluation, counseling, and followup after an occupational exposure that may place the employee at risk for HIV infection. First aid should be administered immediately after any exposure. Puncture wounds and other cut injuries should be washed with soap and water. Exposure to oral and nasal mucosa should be decontaminated by flushing with water. Eyes should be irrigated with clean water and saline or sterile irritants that are

designed for flushing eyes. The exposure should be reported to the person or department, e.g. employee health, infection control, responsible for managing exposures.

Workers with occupational exposures to HIV should receive followup counseling and medical evaluation. HIV antibody tests should be performed at baseline and periodically for at least six months postexposure, e.g. 6 weeks, 12 weeks, and six months. The employee should be counseled on precautions to prevent secondary transmission of HIV.<sup>4</sup>

In some instances, appropriate postexposure management also includes the use of anti-retroviral agents for postexposure prophylaxis (PEP). If PEP is used, drug toxicity monitoring should be included in the medical management and followup of the employee. This article presents the new public health service recommendations for PEP. Although it is the employer's responsibility to offer PEP when appropriate, the employee can refuse to take PEP.



*HIV infection is a risk for health care workers. Recommendations are available for postexposure chemoprophylaxis that correlate the use of antiretroviral agents with the risk of infection.*

An occupational exposure is defined as skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious material. Parenteral contact includes piercing mucous membranes or the skin barrier through such events as a needle stick, human bite, cut, or abrasion. Blood is defined as human blood, human blood components, and products made from human blood. The other potentially infectious materials in addition to blood include the following human body fluids: semen, vaginal secretions, amniotic fluid, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. Any unfixed tissue or organ (other than intact skin) from a human (living or dead) and HIV-containing cell or tissue cultures, organ cultures, and HIV-containing culture medium or other solutions and blood, organs, or other tissues from experimental animals with

HIV infection also are included in the category of other potentially infectious material.<sup>5</sup>

The Centers for Disease Control and Prevention (CDC) has been tracking occupational exposure to HIV. The average risk of HIV infection from all types of percutaneous exposures to HIV-infected blood is 0.3 percent.<sup>6</sup> CDC conducted a case-control study to determine the risk of HIV infection from different types of percutaneous exposures. This case control study showed that the risk of HIV infection exceeded 0.3 percent for exposures that involved a deep injury to the health care worker; visible blood on the device that caused the injury; if the device had been placed in the source patient's vascular system, e.g. a needle used for phlebotomy, or if the source-patient died as a result of AIDS within 60 days postexposure.<sup>7</sup> The increased risk associated in these scenarios may be related to exposure to larger volumes of blood or to blood containing a higher titer of the HIV virus.

The average risk of HIV infection following a mucous

membrane or skin exposure is less than the risk associated with a percutaneous exposure. The average risk of HIV infection after mucous membrane exposure is 0.1 percent. The average risk of HIV infection after skin exposure is less than 0.1 percent. The risk for skin exposure may be increased if skin contact is prolonged, contact involves an extensive area of the skin, the integrity of the skin is not intact, and/or if the exposure involves a higher titer of HIV.<sup>8</sup>

A multinational study found that PEP with zidovudine (ZDV) may reduce the risk of HIV infection. The use of ZDV PEP was shown to decrease the risk of HIV infection following a percutaneous exposure by 79 percent.<sup>7</sup> However, as with chemoprophylaxis measures for other infectious diseases, failures have occurred with ZDV PEP.<sup>5</sup> The reasons ZDV PEP failed to prevent HIV infection in at least 12 cases are not known. However, in 1 case the virus was noted to be partially resistant to ZDV.

Treatment of HIV/AIDS has changed with the development

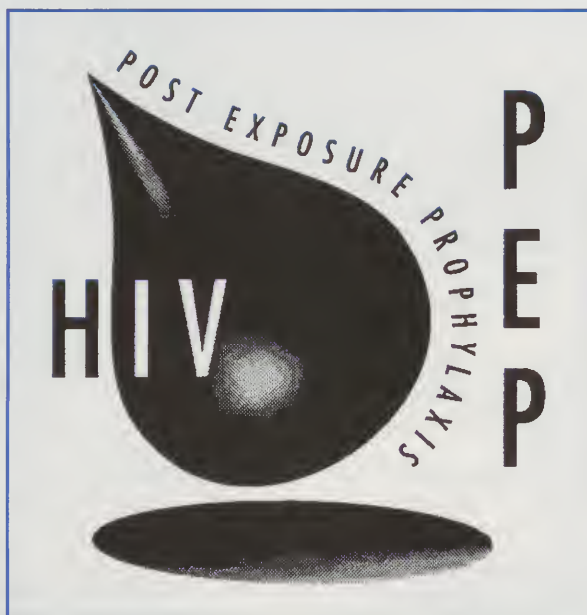
and Food and Drug Administration (FDA) approval of new antiretroviral agents. A Public Health Service interagency group recently used the current gold standard of combination therapy for HIV/AIDS and risk stratification data from the case control study to develop a postexposure management plan. This interagency group with representation from CDC, FDA, Health Resources and Services Administration, and the National Institutes of Health has recommended the use of antiretroviral agents for PEP after certain occupational exposures to HIV. The other aspects of postexposure management, e.g. reporting exposures, counseling and testing of the exposed health care worker, source patient, have not changed.<sup>8</sup>

**Recommendations.** The Table delineates the provisional Public Health Service recommendations for PEP after occupational exposure to HIV. These recommendations are considered to be provisional because they are based on limited data regarding the efficacy and toxicity of the proposed PEP and

risk of HIV infection after exposure. PEP is not recommended for all types of occupational exposure to HIV because the majority of occupational exposures do not result in HIV transmission. For many types of

gible, PEP should be offered. However, the lower risk of HIV infection should be balanced against the side effects of the antiretroviral agents. For exposures with a negligible risk of HIV infection, PEP should not be recommended. When discussing the use of PEP, the employee should be informed that knowledge about the efficacy and toxicity of PEP is limited; for agents other than ZDV, data are limited regarding toxicity in persons who are not HIV infected or who are pregnant; and the employee can decline PEP.<sup>8</sup>

ZDV should be considered as part of all PEP regimens because it is the only agent for which data support the efficacy of PEP in a clinical setting. Lamivudine (3TC) usually should be added to a regimen that includes ZDV because it increases antiretroviral activity and activity against many ZDV-resistant strains. A protease inhibitor should be added to the PEP regimen for exposures with the highest risk of transmission. A protease inhibitor should be considered as part of the PEP regimen for lower risk exposures when a ZDV-resistant strain is likely.



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exposure, the risk of serious side effects may exceed the risk of HIV infection. Therefore, exposures with a lower risk of infection may not warrant the potential side effects of these antiretroviral agents.<sup>8</sup>

Postexposure chemoprophylaxis should be recommended to employees after an occupational exposure associated with the highest risk for HIV infection. For exposures that are not associated with the highest risk, but whose risk is not non-negli-



*An occupational exposure for a health care worker is defined as skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials.*

**Table. Provisional Public Health Service recommendations for chemoprophylaxis after occupational exposure to HIV, by type of exposure and source material, 1996.<sup>8</sup>**

Type of Exposure	Source of material*	Antiretroviral Prophylaxis†	Antiretroviral Regimen††
Percutaneous	Blood**	Recommended	ZDV plus 3TC plus IDV
	Highest risk	Recommended	ZDV plus 3TC ± IDV***
	Increased risk	Offer	ZDV plus 3TC
	No increased risk		
Mucous membrane	Fluid containing visible blood, other potentially infectious fluid**** or tissue	Offer	ZDV plus 3TC
	Other body fluid, e.g. urine	Not offer	
	Blood	Offer	ZDV plus 3TC ± IDV***
	Fluid containing visible blood, other potentially infectious fluid**** or tissue	Offer	ZDV ± 3TC
Skin	Other body fluid, e.g. urine	Not offer	
	Increased risk*****	Offer	ZDV plus 3TC ± IDV***
	Blood	Offer	
	Fluid, containing visible blood, other potentially infectious fluid**** or tissue	Offer	ZDV ± 3TC
	Other body fluid, e.g. urine	Not offer	

\* Any exposure to concentrated HIV, e.g. in a research laboratory or production facility, is treated as percutaneous exposure to blood with highest risk.

† Recommended—postexposure prophylaxis (PEP) should be recommended to the exposed worker with counseling. Offer—PEP should be offered to the exposed worker with counseling. Not offer—PEP should not be offered because these are not occupational exposures to HIV.

†† Regimens: ZDV, 200 mg three times a day; 3TC, 150 mg two times a day; IDV, 800 mg three times a day (if IDV is not available, saquinovir may be used, 600 mg three times a day). Prophylaxis is given for 4 weeks. For full prescribing information, see package inserts.

\*\* Highest risk—both large volume of blood, e.g. deep injury with a large diameter hollow needle previously in source patient's vein or artery, especially involving an injection of source patient's blood, and blood containing a high titer of HIV, e.g. source with acute retroviral illness or end-stage AIDS; viral load measurement may be considered, but its use in relation to PEP has not been evaluated. Increased risk—either exposure to larger volume of blood or blood with a high titer of HIV. No increased risk, neither exposure to larger volume of blood nor blood with a high titer of HIV, e.g. solid suture needle injury from source patient with asymptomatic HIV infection.

\*\*\* Possible toxicity of additional drug may not be warranted.

\*\*\*\* Includes semen; vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial, and amniotic fluids.

\*\*\*\*\* For skin, risk is increased for exposures involving a high titer of HIV, prolonged contact, on extensive area, or on area in which skin integrity is visibly compromised. For skin exposures without increased risk, the risk for drug toxicity outweighs the benefit of PEP.

However, it is unclear if the benefit of adding a protease inhibitor in this instance outweighs the potential side effects. Expert consultation is advised if the strain is ZDV and 3TC resistant, if the strain is resistant to a protease inhibitor, if the medications are poorly tolerated, or if the medications are contraindicated. An HIV strain is more likely to be resistant to an antiretroviral agent if the patient has received the agent for a prolonged time, e.g. 6 to 12 months or longer, or in patients with advanced HIV infection, e.g. CD4+ T-lymphocyte count of less than 200 cells/mm.<sup>3,8</sup>

When PEP is indicated, it should be initiated promptly, preferably within one to two hours postexposure. The interval after which PEP is not effective is unknown. Initiating PEP after a longer interval, e.g. one to two weeks, may be considered for the highest risk exposures. Even if infection is not prevented, early treatment of HIV infection may be beneficial.<sup>8</sup>

The optimal duration of PEP is uncertain. The Public Health Service recommended four weeks of PEP because four weeks of ZDV appeared protective.<sup>6,8</sup>

If the source patient cannot be identified or if the HIV status of the source patient is unknown, initiating PEP should be considered on a case-by-case basis. The factors to be considered include the exposure risk and likelihood of HIV infection.<sup>8</sup>

If PEP is used, drug toxicity monitoring needs to be performed. This should include a complete blood count and renal and hepatic chemical function tests at baseline and two weeks after starting PEP. If subjective or objective toxicity is noted, dose reduction or drug substitution should be considered with expert consultation. Further diagnostic studies may be indicated. Health care workers who become HIV infected should receive appropriate medical care.<sup>8</sup>

The Public Health Service recommendations for PEP are intended to provide guidance to physicians. They can be modified by local experts on a case-by-case basis. Whenever possible, expert consultation is recommended. This is particularly true if an antiretroviral agent is not available, the source patient's virus is likely to be resistant to one or more of the recommended antiretroviral agents, or the antiretroviral

agents are contraindicated or poorly tolerated. The Public Health Service plans to update the PEP recommendations, perhaps annually, as new information becomes available.<sup>8</sup>

The medications recommended for PEP are ZDV, 3TC, and indinavir (IDV), with IDV added to the regimen for the highest risk exposures. In the currently recommended doses, ZDV PEP is tolerated well by health care workers. 3TC also is well tolerated in the doses recommended. Less is known about IDV, but it appears to be well tolerated when used for a short period of time. It is important to remember that IDV should not be used alone. IDV also has adverse interactions with many medications and these interactions should be checked prior to prescribing IDV. The frequent side effects that have been reported include gastrointestinal symptoms (nausea), fatigue, and headache for people taking ZDV and 3TC; pancreatitis with the use of 3TC; and jaundice and kidney stones in people taking IDV. However, the side effects associated with IDV are rare when it is taken for less than one month. The risk of kidney stones can be further reduced by drinking at least 48 ounces of fluid per 24-hour period.<sup>8</sup>



Currently, the FDA has approved ZDV, 3TC, and IDV for the treatment of HIV infection, but not for PEP. However, physicians may prescribe any FDA-approved medication when, in their professional judgment, use of the medication is clinically indicated.

Currently only limited data are available on the side effects and toxicity of antiretroviral agents in people who are not HIV infected. To learn more about the safety and outcome associated with PEP, health care providers are encouraged to enroll all workers who receive PEP in an anonymous registry that was started on July 15, 1996. The registry is a collaborative effort among CDC, Glaxo Wellcome Inc., and Merck and Co., Inc. The specific information requested in the registry includes exposure, antiretroviral agents that are taken, abnormal laboratory findings, and physical symptoms associated with using these antiretroviral agents. Participation in the registry is voluntary and anonymous. Health care workers and providers can learn more about the registry by calling toll-free at 1-888-737-4448.<sup>8</sup>

More information about health care worker occupational exposure to HIV is available

from several sources. The CDC has a National AIDS Hotline (1-800-342-2437) with trained information specialists to answer questions on HIV infection and AIDS. The AIDS Treatment Information Service/ATIS can be contacted (1-800-933-4313) for information on the clinical treatment of HIV/AIDS. Free copies of printed material on HIV infection and AIDS can be obtained from the CDC National AIDS Clearinghouse (1-800-458-5231).

Beginning in early 1997, updated information on HIV PEP will be available from multiple sources. These include: the CDC home page on the Internet (<http://www.cdc.gov>); CDC's fax information service (404-332-4565); the National AIDS Clearinghouse (1-800-458-5231); and the HIV/AIDS Treatment Information Service (1-800-448-0440).<sup>8</sup>

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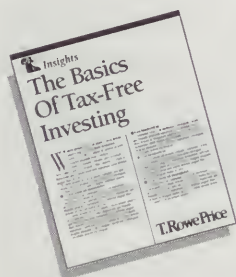
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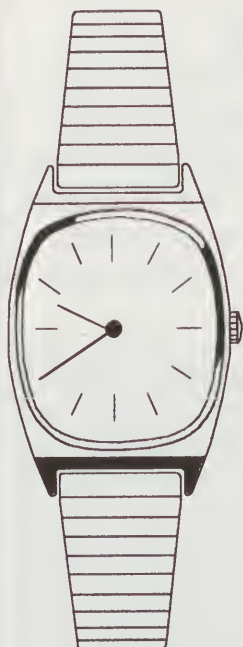
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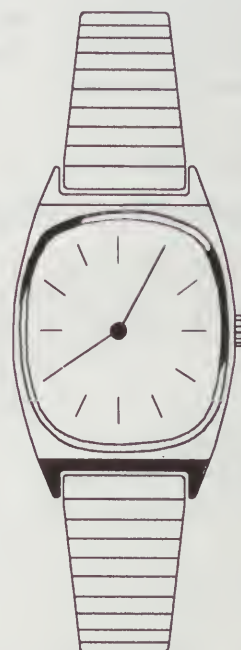
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## LIABILITY CONCERNS IN MANAGED CARE

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In the past, it was well known that medical decisions were made by physicians, whether they practiced in their offices or in hospitals. It also was clear that physicians had a legal duty to render care with at least that degree of skill and knowledge ordinarily possessed by practitioners in the same specialty, working under similar circumstances.

Managed care has changed the context in which patient care takes place. The hospital no longer is the main locus of medical practice and physicians are involved in many

groups, networks, HMOs, IPAs, preferred providers, and other managed care organizations. As a consequence, the process of health care decision making has become extraordinarily complex and the courts and legislators are struggling to determine not only who should be legally responsible when a patient is injured, but also what is the appropriate legal foundation for liability. This report summarizes these trends, and alerts readers to developments in this area of the law.

Previously, when a malpractice plaintiff filed a lawsuit, there were two parties from which to choose—the doctor and the hospital—and negligence was virtually the only theory of liability. By comparison, courts today are finding liability on the part of individual physicians (both as employees and independent contractors), hospitals, HMOs, and IPAs. Some courts also are beginning to find liability against insurance carriers and utilization review organizations whose decisions have been found to interfere with medical decision making. These claims are brought under theories of both negligence and contract

law. In the remainder of this report, we discuss examples where courts have extended liability into these areas.

**Marketing liability.** As managed care organizations vie for all-important market share, promotional and marketing materials have been commonplace, along with the individual or group contracts with the plan beneficiaries. Emerging theories have relied upon these materials to impose liability upon managed care organizations and their physicians.

Increasingly, managed care organizations have become the enrollee's single source of health care services. For instance, in an IPA-model HMO, subscribers pay an annual fee and choose physicians from a list of approved physicians provided by the HMO. In most cases, the fact that the physician is listed by the HMO as an approved provider suggests to subscribers that the credentials are acceptable to the HMO.

This inference formed the basis for one court to find that the HMO could be construed as conducting itself as a provider and therefore would



## *Managed care organizations and their staffs and representatives must recognize that marketing efforts can form the basis of liability claims.*

be subject to the same liabilities as other providers. *Decker v. Saini*, 14 Employee Benefits Cases 1556, 1991 WL 277590 (Mich. Cir. Ct., Sept. 17, 1991). The Court relied upon the legal theory of "ostensible agency." Since 1991, other courts have used this case to extend liability to managed care organizations when the following elements are present: the patient reasonably believed that the doctors were agents of the HMO; the HMO made this representation; and the patient's reliance on this belief was not negligent.

Courts can be expected to look at the specific facts surrounding how the managed care organization is operated and organized in such instances. In one case, a court identified that the HMO promised that it provided quality health services and benefits to members; members paid their fees to the HMO, not to the physicians; the HMO provided a limited list from which members could choose their primary care physician; members had no choice of which specialist to see; and the primary care physicians were screened by the HMO. On this basis, a case for negligent selection and retention of providers was allowed to go



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forward against the HMO. *Boyd v. Albert Einstein Med. Center*, 547 A.2d 1229 (Pa. Super. Ct. 1988).

In some instances, courts have gone further to find fraud or misrepresentation in the promotional efforts of the managed care organization, and have allowed claims for punitive damages to go forward. Such claims have been based upon an HMO's suggestion that its physicians were screened vigorously, were qualified, and would promptly refer patients to appropriate specialists. *McClellan v. Health Maintenance Organization of Pennsylvania*, 604 A.2d 1053 (Pa. Super. Ct. 1992). In New Jersey, a court has opined that claims for fraudulent misrepresentation might be reviewed

under the New Jersey Consumer Fraud Act, if the managed care documents in which the alleged misrepresentations are contained are not the subject of regulatory review by the Departments of Health and/or Insurance. *Hampton Hospital v. Bresan*, \_\_\_ N.J. Super. \_\_\_, No. A-6402-94T5 (App. Div. Mar. 13, 1996). As New Jersey HMO law requires that most of these documents are reviewed by the Departments of Health and Senior Services and/or Insurance, this type of claim should not appear frequently in this state.

In sum, managed care organizations and their staffs and representatives now must recognize that the organization's marketing efforts can form the basis of professional liability claims.

## *The role of the physician who acts as gatekeeper in the managed care setting has become increasingly complex and critical.*

**Gatekeeper liability.** The role of the physician who acts as a gatekeeper in the managed care setting has become increasingly complex and critical. Not only must the physician provide medical services to patients, the physician also determines when specialty consultations are needed, coordinates care between specialists, approves or must seek approval from the payor for hospitalization, and may have to seek payment for specialty providers. In all, payors have attempted to shift the legal responsibility for cost control to the gatekeeper. While courts may be expanding the payor's liability for decisions to control costs that are tantamount to medical decisions about the patient's treatment, the liability of the gatekeeper physician is not necessarily lessened as a result.

The case of *Dunn v. Praiss*, 139 N.J. 564, 656 A.2d 413 (1995), illustrates the problems that can occur when the primary care or family physician acting in the expanding role as a gatekeeper, does not adequately provide for and manage the patient's care. According to the report of this case, Mr. Dunn's primary care physician referred the patient to a

urologist based upon his diagnosis of epididymitis. The urologist failed to detect the testicular cancer, to which Mr. Dunn eventually succumbed. Significantly, the court believed that the family doctor did not follow up with the urologist to monitor the diagnosis and treatment, after the patient had been referred. The New Jersey Supreme Court held that the HMO whose breach of contract was found to be one cause of the plaintiff's injury, must make a monetary contribution to the physicians found liable to the plaintiff for malpractice.

The *Dunn* case offers the possibility that the physician who is sued may receive some contribution from the HMO with whom the physician contracts for service. Nonetheless, it is clear that the actions of gatekeeper physicians can lead to liability for negligent failure to followup and monitor referrals to specialists.

**Cost containment.** Financial incentives offered by third-party payors to elicit physicians' cooperation in reducing utilization have been considered interference with treatment decisions. In such cases, liability can be imposed upon the physician, managed

care organization, utilization review, and/or insurance company. This theory was first recognized by the California courts and continues to gain recognition in other jurisdictions.

Indeed, the first case where a plaintiff tried to tie a payor of health care services into the causation chain of medical malpractice, alleged that premature discharge from the hospital caused her injury. The court held that as a payor, Medi-Cal could only breach its duty to the patient if appeals from the patient's physician had been, "arbitrarily ignored or unreasonably disregarded or overridden," or if Medi-Cal's procedure had corrupted the physician's medical judgment. The court also found that when defects in the design or implementation of a cost-containment program result in inappropriate medical decisions, anyone involved in the patient's care, including third-party payors, can be held liable. *Wickline v. State of California*, 192 Cal. App.3d 1630, 239 Cal. Rptr. 810 (App. 1986).

In another California case, *Hughes v. Blue Cross of Northern California*, 263 Cal. Rptr. 850 (1989), cert. denied, 495 U.S. 944 (1990), the

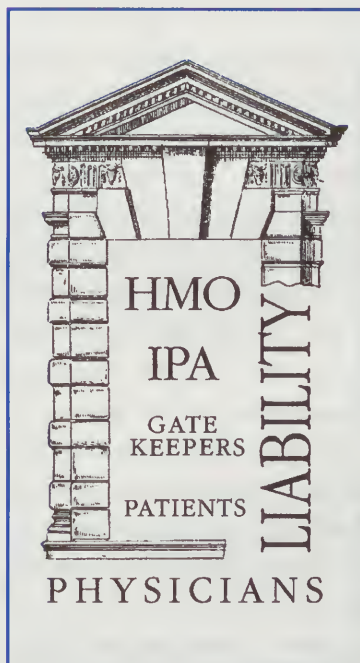


## *The fact that the HMO or managed care utilization review company may have dictated the treatment does not relieve the physician of responsibility.*

California Court of Appeals affirmed a trial court's award of \$850,000 in punitive and compensatory damages against Blue Cross for a utilization review determination of medical necessity that was found to be based on a conscious disregard of the rights of the insured. This case involved the denial of claims for the psychiatric hospitalization of a patient with severe mental illness. The court found that the Blue Cross reviewer routinely devoted 12 minutes to the review of each claim, and in this case, had not reviewed a majority of the patient's hospital records. The court based its decision on this inadequate review procedure, together with the consultant's disclaimer of any obligation to investigate the case, and the use of a medical necessity standard that did not conform to the community standard.

In a particularly dramatic case, the plaintiff was awarded a jury verdict against HealthNet, one of California's largest for-profit HMOs, in the amount of \$12.1 million compensatory and \$77 million punitive damages, based upon HealthNet's denial of payment to a breast cancer patient for a bone marrow transplant. HealthNet viewed the procedure as exper-

imental or investigational, despite the fact that it had a \$4.2 million fund to pay for the very type of procedure the patient sought. A contributing factor in this huge verdict surely was the incentive bonus plan for medical executives who refused payment for expensive treatments. *Fox v. HealthNet of California*, Civ. No. 219-692 (Cal., Riverside County Super. Ct., Dec. 28, 1993).



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These cases graphically illustrate the results that may occur when the cost containment function of a managed care organization is substituted for the independent medical judgment

of the physician. Medical judgment must prevail or the results may be disastrous.

**Conclusion.** It is clear that physicians, as well as managed care organizations, are exposed to new theories of liability related to new modes for the delivery of health care services. In response, many physician contracts with managed care entities recite that all decisions made by the physician are based on medical judgment alone, and are not influenced by cost considerations. In reality, as the above litigation illustrates, the courts are recognizing that this is not the case. Unfortunately, for the physician, the fact that the HMO or managed care utilization review company may have dictated the treatment or lack thereof does not relieve the physician of responsibility as the prime patient care decision maker.

As illustrated by this report, all physicians must read and be aware of the contents of managed care contracts they sign, and/or are entered into on their behalf. The terms of these agreements will play an important part in determining the rights of all providers, should a medical malpractice case occur.

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(signed) Geraldine R. Hutner  
Managing Editor

# COMMENTARY

## Building consensus in health care decision making

*Richard V. Sinding*

There was a time in America, notably in the 19th century, when compromise was not a dirty word. In fact, the notion of making some small sacrifice for the larger public good was considered admirable, and the political goal of achieving consensus was thought to be among the noblest pursuits in a participatory democracy.

In those days, Henry Clay was hailed as the "Great Compromiser"—a term of utmost respect—for his ability to find solutions to difficult problems through careful and painstaking negotiations, embracing all parties and perspectives. From this philosophy of governing, this commitment to building consensus, arose the uniquely American axiom: "Politics is the art of compromise."

That was then. This is now.

Today, politics in America is the art of winning. Today, to make any concession, large or small, for the broader public good is perceived as an act of cowardice, an unseemly willingness to sacrifice ideological principle for political expediency. Today, compromise is a synonym for surrender, and the art of consensus-building has about as much relevance to the political process as a convention of the Whig Party.

Today, Henry Clay would be the target of every special-interest lobby in Washington, DC, and his political opponents back home in Kentucky would delight in airing 30-second spots that made prominent and derisive mention of his now-scornful sobriquet.

Throughout America, where public discourse once was rational and conciliatory, it is now raucous and confrontational. In the political arena, reasonableness has been replaced by rancor. In deliberative bodies, where people used to go to settle fights, they now go to start them.

In this new era of power politics, we must face a stark reality. For all its attributes, our system of representative democracy as it



presently functions is not capable of—nor are its practitioners much interested in—the fine art of building consensus. It is left to civic-minded individuals and organizations to provide a forum for honest, substantive, reasonable, and responsible discussion and debate of the public policy issues confronting our society.

Enter New Jersey HEALTHDECISIONS.

Formerly the 'Citizens' Committee on Biomedical Ethics, New Jersey HEALTHDECISIONS stands for the principle that public awareness and participation are the keys to intelligent and responsible decision making. A non-profit, grassroots organization, New Jersey HEALTHDECISIONS is supported by a major grant from The Robert Wood Johnson Foundation, generous contributions from The Prudential Foundation and The Fund for New Jersey, corporate and individual donations, and membership dues.

Regardless of the issue—whether it's the efficacy of advance directives for health care, the latest court ruling on physician-assisted suicide, the ethical implications of genetic research, the effect of managed care contracts on the physician-patient relationship, or how to pay for charity care—New Jersey HEALTHDECISIONS believes that sound

solutions will be found through the kind of wide-ranging, broad-based, inclusive public discussion in which our consensus-seeking forefathers so willingly and effectively engaged.

The need for an independent broker to negotiate this kind of discussion is particularly pressing in the field of health care. Not only is the debate over

the future of health care in this state and this nation an increasingly acrimonious one, but the traditional function of government to serve as the objective moderator of this debate has been irreparably damaged by two factors—first, the erosion of public confidence in govern-

ment to perform this function in general, and second, the perception that government, as both a provider and consumer of health care, has a vested interest in the outcome of this particular debate.

And it does.

Government, as the administrator of such enterprises as the public health service and the National Institutes of Health, as the manager of military and veterans' hospitals at the federal level and myriad public hospitals at the state, county, and municipal levels, as

## COMMENTARY



the operator of countless other federal, state, and local health facilities and programs, is a major provider of health care for millions upon

## COMMENTARY

millions of Americans. At the same time, government as the benefits-providing employer of military and civilian personnel, as the sponsor and subsidizer of the mammoth Medicare and Medicaid programs, as the payer of last resort for the growing rolls of patients requiring charity and indigent care, is a major consumer of health care.

Performing both of these roles, government has a hard enough time resolving its own internal conflicts, much less taking on broader societal ones. Consider, for example, the failure of the Clinton administration's health care reform initiative, blamed in almost equal parts on the intractability of the stakeholders who were threatened by it and the absence of any kind of direct citizen input that might have helped overcome such entrenched opposition. Or, closer to home, last spring's debate in the New Jersey Legislature over funding charity care, which, after months of sparring between Democrats and Republicans,

mostly pitting city hospitals against suburban taxpayers, produced a sloppy, stop-gap solution with no discernable victors.

The future of health care is too important to be decided by closed-door discussion, partisan one-upsmanship, or power politics. Reasoned dialogue and debate, involving all sectors of society, represent our best hope for charting a health care future that provides the greatest good for the greatest number of our citizens.

Perhaps the day will come when the



political process once again encourages this kind of discussion, when government once again is perceived as an objective mediator

of public disputes, rather than a stakeholder in their outcomes.

Until then, it is left to other institutions to keep the flames of civic involvement burning. One such institution is New Jersey HEALTHDECISIONS. We stand ready to perform our civic responsibility—in the worthy spirit of compromise, in the noble pursuit of consensus, and, above all, in the broad public interest.

*Mr. Sinding is executive director, New Jersey HEALTHDECISIONS, Inc., Princeton.*

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## CAN WE AFFORD MEDICAL SAVINGS ACCOUNTS?

*Louis L. Keeler, MD*

*It is documented that MSAs save money for patients and employers because consumers shop wisely with their own money.*

Finally, medical savings accounts (MSAs) are a reality. Actually, they have been around for several years, but the contribution was not tax deductible until recent legislation.

MSAs are a high deductible health insurance policy. According to the federal law, the

deductible must be at least \$1,500 and no more than \$2,250 for an individual and at least \$3,000 and no more than \$4,500 for a family. The remainder of the contribution goes toward a catastrophic health insurance policy to cover all costs over the deductible in that year. The money in MSAs can only be spent on health care. This is reasonably defined in the legislation. Also, the money must be placed in a separate trust account. Unused monies in the account can accumulate over the years.

At age 65, the money can be withdrawn without penalty. This could be a sizable nest egg. For example, a 20-year-old who spends the statistical average on health care each year and contributes \$1,800 a

year for 45 years until age 65 would have \$334,000 at retirement. Considering the insolvency of Medicare, this is a fairly nice nest egg to provide health insurance, supplemental health insurance, or long-term care.

It is documented that MSAs save money for patients, employers, and the system because consumers shop wisely when spending their own money. A Rand Corporation study showed that when paying out of their own pocket consumers purchased 30 percent less in medical care than fully covered consumers—with no difference in outcomes.

Eighty-nine percent of health insurance company claims are less than \$2,000 per person per year. This means that health insurance companies spend most of their time adjudicating medical claims that are unnecessary.

There are five criticisms of MSAs that do not stand up under careful scrutiny:

1. MSAs would attract only healthy people, leaving sick people in a separate pool.

2. MSAs would attract only wealthy people looking for a tax break.

3. MSAs will never provide enough money for people to pay their health care bills.

4. MSAs will cost the employers more money. It has been reported that employers save money, as shown by Jersey City, New Jersey; ADA County,



*Louis L. Keeler, MD*



Idaho; *Forbes* magazine; and The Golden Rule Insurance Company.

5. MSAs are being promoted by special interest groups. (The opposite is true. MSAs are only advantageous to the consumer. Patients make their own health care choices. The liberal legislator, such as Senator Kennedy, sees patient choice as the antithesis of what can be achieved legislatively: a single payor system. If government lets this work, then consumers will never buy into their collectivist mentality.)



Dr. John Lanzaletti, a Virginia plastic surgeon, has developed a scenario that encompasses the Medicare and Medicaid populations, workmen's compensation, and the uninsured population. It has been passed by the Virginia Legislature and awaits only congressional approval of MSAs tax-free status. Dr. Lanzaletti's Jefferson Health Policy Foundation estimates that if the Virginia legislation were adopted nationally, it would save the entire system \$200 billion per year and I believe it.

On January 30, 1999, only 750,000 people can have an MSA—1 out of every 267 citizens. By January 1, 1999, the comptroller general must submit to Congress a comprehensive study regarding the effects of MSAs in the small group market. It is obvious that what

happens to MSAs is dependent upon who is in power in 1999.

The Physician's Healthcare Plan of New Jersey is in the process of developing an MSA product, specifically for physicians and their staffs. Assemblyman Richard Bagger, Republican District 22, has introduced a MSA bill (A-671) to the recently passed federal legislation.

MSNJ and the American Medical Association support MSAs. Now that there is an opening, however small, we must capitalize on it and over the next three years do all we can

to make MSAs available to any citizen that chooses this form of health insurance.

*Dr. Keeler is a past-president of MSNJ and a member of the Review Board of New Jersey Medicine.*

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Bill A-671, concerning MSAs, was introduced by Assemblymen Bagger and Roma. The medical community seems divided on this issue. What are your thoughts on MSAs? Do you think MSAs will help lessen the costs of health care? Will MSAs change the way patients seek health care? FAX us your comments at 609/896-1368.

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NOVEMBER 6th

**The Changing Face of Community-Acquired Pneumonias: The Impact of Pneumococcal Resistance**

*Daniel N. Musher, M.D.*

Professor of Medicine, Microbiology and Immunology

Baylor College of Medicine, Chief, Infectious Diseases, VA Medical Center, Houston, TX

NOVEMBER 13th

**H.pylori—Revelation to Revolution**

*David A. Peura, M.D.*

Professor of Medicine

University of Virginia Health Sciences Center  
Associate Chief, Division of Gastroenterology  
Charlottesville, VA

NOVEMBER 20th

**Progression of Renal Disease in African Americans with Hypertension**

*George L. Bakris, M.D.*

Associate Professor of Preventive and Internal Medicine

Department of Preventive Medicine, Director

Rush Hypertension Program, Rush-Presbyterian-St. Luke's Medical Center  
Chicago, IL

NOVEMBER 27th

**No Grand Rounds**

### DECEMBER 1996

DECEMBER 4th

**Genetic Models of Hypertension**

*Richard P. Lifton, M.D., Ph.D.*

Associate Professor of Medicine, Nephrology, and Genetics

Yale University School of Medicine, Assistant Investigator, Howard Hughes Medical Institute  
New Haven, CT

### DECEMBER 1996

DECEMBER 11th

**Cardiac Auscultation for the Generalist and Office Practice**

*Bernard L. Segal, M.D.*

Clinical Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, MCP Division  
Philadelphia, PA

*Gerald Scharf, D.O.*

Clinical Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

*Dean G. Karalis, M.D.*

Clinical Assistant Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

*Farooq Chaudhry, M.D.*

Professor of Medicine

Division of Cardiovascular Diseases, Director Cardiac Echo Labs, Allegheny University Hospitals Hahnemann Division, Philadelphia, PA

*John J. Ross, Jr., RCPT, RDCS*

Research Assistant Professor

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

DECEMBER 18th

**Advances in the Use of Interferon**

*Moshe Talpaz, M.D.*

Professor of Medicine

University of Texas School of Medicine, Interim Chairman, Department of Bioimmunotherapy  
M.D. Anderson Cancer Center, Houston, TX

DECEMBER 25th

**No Grand Rounds**

### JANUARY 1997

JANUARY 1st

**No Grand Rounds**

JANUARY 8th

**Domestic/Spousal Abuse**

*Sarah Buel, J.D.*

Adjunct Professor

Harvard School of Medicine and University of Texas School of Law, Special Counsel, Texas District and County Attorneys Association  
Austin, TX

JANUARY 15th

**Telemedicine—The Future of Medical Education and Practice**

*Jay H. Sanders, M.D.*

Senior Scientist

Georgia Institute of Technology, McLean, VA

JANUARY 22nd

**Reversing Endothelial Dysfunction with ACE Inhibitors**

*D.B. John Mancini, M.D.*

Professor and Head, Department of Medicine  
University of British Columbia, Vancouver Hospital and Health Sciences Center, Vancouver, British Columbia, Canada

JANUARY 29th

**Indications and Findings of Lower GI Endoscopy**

*Jerome Waye, M.D.*

Clinical Professor of Medicine

Mt. Sinai School of Medicine, Chief, GI Endoscopy Units, Mt. Sinai Medical Center and Lenox Hill Hospital, New York, NY

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Allan B. Schwartz, M.D., Farooq Chaudhry, M.D.,  
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John J. Ross, Jr., RCPT, RDCS

JANUARY 22, 1997

**Advances in Diagnosis and Management of Cardiovascular Disease**

Course Co-Directors: Marc Cohen, M.D.,  
Susan Brozena, M.D.

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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### **Neuro-ophthalmology Update**

November 9, 1996  
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### **Dermatology Meeting**

November 12, 1996  
Location to be announced  
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### **Radiation Oncology Meeting**

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November 15, 1996  
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November 15-16, 1996  
Kessler Conference Center, West Orange  
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November 20, 1996  
Warren Hospital Phillipsburg  
908/859-9546

### **Health Care Benefits Purchaser Workshop**

November 20, 1996  
Holiday Inn, Cranbury  
800/398-9457

### **Wound Care Conference**

November 21, 1996  
Kessler Conference Center, West Orange  
201/731-3600

### **Radiology/Ultrasound Meeting**

November 21, 1996  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **Renaissance Medical Students**

November 21, 1996  
George F. Smith Library, Newark  
201/982-6293

### **Identification of New Targets in Stroke Research**

November 22, 1996  
UMDNJ, Stratford  
609/566-6000

### **Women's Health**

November 22-23, 1996  
Holiday Inn, Atlantic City  
609/348-2200

### **Aspects of HIV/AIDS**

November 26, 1996  
Trenton Psychiatric Hospital  
609/633-1500

### **TB and the Law**

December 2, 1996  
UMDNJ, Newark  
201/982-4267

### **Infection Control in the HIV Era**

December 4, 1996  
Veterans Medical Center, Lyons  
908/647-0180

### **Tumor Board Conference**

December 4, 1996  
Hyatt Regency, New Brunswick  
908/873-1234

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### **Postprandial Hyperglycemia**

December 6, 1996  
Marlboro Psychiatric Hospital  
908/946-9081

### **Public Policy Forum**

December 6, 1996  
Sheraton, Iselin  
609/393-7707

### **Dermatology Meeting**

December 10, 1996  
Location to be announced  
609/275-1911

### **Telemedicine in the 1990s**

December 11, 1996  
Health Sciences Library Assoc.  
201/996-2326

### **Radiology Meeting**

December 19, 1996  
Location to be announced  
609/275-1911

### **Ultrasound Meeting**

January, 1997  
JFK Conference Center, Edison  
908/632-1615

### **Asymptomatic HIV Infection**

January 8, 1997  
Rahway Hospital  
908/381-4200

### **Psychosocial Aspects of HIV/AIDS**

January 8, 1997  
Veterans Medical Center, Lyons  
908/647-0180

### **Management of Asymptomatic HIV Infection**

January 9, 1997  
Newcomb Medical Center, Vineland  
609/691-9000

### **Potentials/Magnetic Stimulation**

January 10-11, 1997  
Kessler Conference Center, West Orange  
201/731-3600

### **Macular Degeneration**

January 11, 1997  
Scheie Eye Institute  
215/662-8100

### **Dermatology Meeting**

January 14, 1997  
Location to be announced  
609/275-1911

### **Domestic Violence Issues for Physicians**

January 15, 1997  
Union Hospital  
908/687-1900

### **Diagnosis and Treatment of AIDS**

January 15, 1997  
Mediplex Rehab Hospital, Marlton  
609/988-8778

### **Radiology Meeting**

January 16, 1997  
Location to be announced  
609/275-1911

### **Handling Violent Patients**

January 16, 1997  
Woodbridge Developmental Center  
908/499-5500

### **Nephrology Monthly Meeting**

January 21, 1997  
Overlook Hospital, Summit  
908/522-2000

### **Anesthesiology Meeting**

January 21, 1997  
Forsgate Country Club  
908/521-0070

### **Visiting Professor Lecture**

January 23, 1997  
St. Barnabas Medical Center, Livingston  
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**December 4, 1996      Reperfusion in Acute Myocardial Infarction: Short and Long-Term Benefits and Complications**  
**Moderator: J. David Ogilby, M.D.**

**January 8, 1997      Office Cardiology: Bedside Diagnosis of the Cardiac Patient, Part II**  
**Moderators: Michael S. Feldman, M.D.**  
**Bernard L. Segal, M.D.**

**Upcoming programs:**

February 5, 1997      —Gender Differences in Heart Disease  
March 5, 1997      —Controversies in Stress Testing  
April 2, 1997      —Syncope: Simple Faint to Sudden Cardiac Death

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# editorial guidelines

## Editorial Guidelines

The principal aim in the preparation of a contribution should be relevance to health care and to the education of patients and health care professionals. The contents of each issue include an important health care development; an indepth interview highlighting a health care newsmaker; an update on a key public health issue; a peer-reviewed clinical report; brief highlights of the latest events and findings in the health care industry; and a monthly forum for readers. Proposals for special submissions will be considered on an individual basis. Letters to the editor are welcome and will be edited and published as space permits. Notices of events, programs, and meetings are encouraged.

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and the authors will be permitted. Upon acceptance, authors will have the opportunity to review edited material. All communications should be sent to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648.

## Specifications

Materials compatible with Microsoft Word 6.0 for Windows should be submitted on diskette (3 1/2 inch), and should be accompanied by a printed copy of the material, a cover letter identifying the submission, and a copyright form.

The title page should include the full names, degrees, and affiliations of all authors, and the name and address of the author to whom correspondence should be sent.

The author(s) should submit a 30-word abstract to be used at the beginning of the article. References should not exceed 35 citations and should be cited consecutively by superscripted numbers at the end of the sentence. The style of *New Jersey MEDICINE* is that of *Index Medicus*: 1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977. Tables and graphs should be presented at the end of the article. Illustrations should be of professional quality, black and white glossy prints. The name of the author, figure number, and top of the figure should be clearly marked on the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission signed by the subject or responsible person must be included. Materials taken from other publications must give credit to the original source. Generic names should be used with proprietary names indicated parenthetically with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol.





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continued from page 80

## Ocean County physician named to board

**Charles R. Markowitz, MD**, of Ocean Township, has been appointed by Governor Whitman to the Orthotics and Prosthetics State Board of Examiners, in the Division of Consumer Affairs. Dr. Markowitz will help plan and implement policies pertaining to the manufacture and distribution of orthotic and prosthetic devices as well as the licensing of orthotists and prosthetists. Dr. Markowitz is medical director and chief of Physical Medicine and Rehabilitation at Kimball Medical Center, Lakewood. Dr. Markowitz is a member of MSNJ.



Charles R. Markowitz, MD

## Kessler's director joins arthritis board

MSNJ member **Marca L. Sipski, MD**, medical director at West Orange's Kessler Institute for Rehabilitation, has been elected to the Board of Directors of the Arthritis Foundation, New Jersey Chapter. At Kessler, Dr. Sipski serves as project co-director of the Northern New Jersey Spinal Cord Injury System, a federally designed model system for the treatment of spinal cord injuries. Dr. Sipski is a member of the AMA.



Marca L. Sipski, MD

## Survey: Physicians and jury duty

At the 1996 MSNJ Annual Meeting, the House of Delegates adopted Resolution #13 (**Physicians and Jury Duty**) and Resolution #50 (**Physician Exemption from Jury Duty**): Resolved, that MSNJ seek an amendment to the New Jersey statute that permits physicians in active clinical practice to be exempt from jury duty because of their unique relationship and responsibilities to their patients.

**Should physicians be exempt from serving jury duty? Have you ever served on a jury? Have you ever received a summons to serve?** Write us about your experience. Please FAX or mail your response to: *New Jersey MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648, FAX 609/896-1368.

## Proposed PIP notification rules

The Department of Banking and Insurance has proposed new rules to implement a personal injury protection (PIP) automobile insurance law signed last January by Governor Whitman.

The law was conceived to combat fraud by nonphysician providers who were "stockpiling" bills for treatment—sometimes dumping more than a year's worth of bills on automobile insurers. The response is a requirement to notify insurance carriers within 21 days of commencement of treatment. In turn, the carrier must notify the treating provider, within 14 days, of the patient's coverage status.

If the notice is made after 21 days, the insurer is required to advise the provider in writing of the late notification and is entitled to deny or reduce payment for all eligible charges.

The rule also would require insurers to include on the reverse of all insurance identification cards, among other things, the requirement of 21-day notice to the insurer.

Exempt from the notification requirements are most providers who only provide services upon the prescription of another provider and emergency care providers.

The Department of Banking and Insurance also has recently announced it will not adopt regulations that would permit automobile insurance companies to offer their policyholders the option of managed care for medical expense benefits provided under PIP coverage.

There are two bills that address PIP coverage. One would allow policyholders to select a PIP managed care option, which MSNJ finds problematic. An alternative bill, which MSNJ supports, would establish a peer review program for PIP claims.

**NJM**



# MSNJ AND RUTGERS GRADUATE FIRST CLASS

# F.Y.I.

**The Medical Practice Manager Program, presented by MSNJ and Rutgers, the State University of New Jersey, graduated its first class. These graduates are equipped to address the diverse management challenges affecting today's medical practice manager and also acquired state-of-the-art office automation techniques.**

The Medical Practice Manager Program presents medical practice managers a unique opportunity to obtain college credit, computer skills, modern management techniques, and knowledge about the changing health care environment in a flexible, convenient format. The program is divided into three courses. "Computers and Medical Technology," an introductory program brings novice computer users into the computer age. "Management Issues and Strategies" introduces the student to traditional and newly developed concepts in medical office management. "The Medical Environment" provides the student with a general overview of the changes in the health care setting.

## **Sinagra nominated for AMA award**

State **Senator Jack Sinagra** of Edison was honored by MSNJ President Anthony P. Caggiano, Jr, MD, with a nomination for the prestigious Doctor Nathan Davis Award. Senator Sinagra is an outstanding public servant, striving, through his leadership in the Senate, for a tobacco-free environment for children. He also has sponsored legislation to establish controls on managed care companies. Nominees from southern states,



© Double Exposure

*Senator Sinagra and Dr. Caggiano*

however, swept this year's Davis honors, awarded by the American Medical Association.



*MSNJ President Anthony Caggiano, MD, (left) congratulates 9 of the 17 graduates of the Medical Practice Manager Program.*

The program has met with a favorable response. One office manager commented, "I have been able to apply all segments of the course on a daily basis to deal with staff, OSHA regulations, and computer-related issues, including the choice of a new software system." Many students like the flexible sched-

ule where time lost from the office is minimal. Another office manager felt that the program gave her more confidence to solve complex management problems.

For registration information, contact Julie Jadlocki, 609/896-1766, extension 209.

*continued on page 79*

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New Jersey MEDICINE

## newsWATCH

Wellness—or as one health professional termed it recently, “wellness prevention”—is rapidly becoming the chief consumer goal in health care. Beneficiaries of this trend include primary care practitioners, alternative medicine folks, and sports medicine clinics. In communications with patients, consumers, and payers, savvy physicians and providers are couching their services in wellness terms.

One aspect of wellness, certainly, is mental health. Although mental health care is seen as the bane of payers, it's the disease of **clinical depression** that costs U.S. businesses \$44 billion annually. Judging from figures released by the **National Institute of Mental Health**, as many as three million affected Americans would thrive under therapy that they are not now receiving. The new federal **Mental Health Parity Act** prohibits employers who offer mental health care coverage from attaching dollar caps. But, the law will not go into effect until 1998 and does not cover small employers.

Unwell with back pain attributed to a herniated disc, **Governor Whitman** recently had to cancel an appearance with **Medical Society of New Jersey (MSNJ)** leaders. A recent analysis by the **Agency for Health Care Policy and Research** related lumbar discectomies to quality-adjusted life years. Fortunately, Mrs. Whitman recovered in time to undertake an arduous trip to Israel and France less than two weeks later.

Declaring “the health and well-being of

New Jerseyans a top priority,” the Governor signed legislation on November 7 to mandate HMOs and insurers to pay for annual **prostate cancer screening**, the male health issue of the year. HMOs and the business community did not object to the specific mandate.

Far more emotional an issue is the new female health issue, **length of stays for mastectomies**. Expect early discharges for breast cancer patients to be the new club leveled at HMOs. Heat is being radiated on the duration of hospital stay, while little light is shone on the full continuum of the patient's care.

**So, enough wellness, already. Let's talk politics. Changes in faces in the U.S. Senate include the addition of several figures with substantial health-related experience. Among the senators-elect, Max Cleland (D-GA) is a former head of the Veterans Administration, Pat Roberts (R-KN) is a health policy wonk and advocate of medical savings accounts, Wayne Allard (R-CO) is a veterinarian, and Dick Durban (D-IL) has been a thorn to the pharmaceutical and tobacco industries.**

*Medicine & Health Perspectives* notes that six members of the **Senate Special Committee on Aging**, including respected chairman **William Cohen** of Maine, are going. Also departing is Labor and Human Resources Committee chair **Nancy Kassebaum** of Kansas, who probably will be replaced by fellow moderate **James Jeffords** of Vermont. All Senate and House committee chairs are, of course, Republicans.

Among new House members, the newsletter also notes that **Ron Paul** (R-



TX) is an obstetrician-gynecologist and one-time Libertarian candidate for president; **Vic Snyder** (D-AR) is the deadly combination of a physician-attorney; **John Cooksey** (R-LA) is an ophthalmologist; **Brian Baird** (D-WA) is a psychologist; and **Carolyn McCarthy** (D-NY) is a nurse whose husband was slain in the Long Island train mass murder.

Four counties are rolling out the state **Department of Health and Senior Services'** new one-stop shopping program for seniors, **NJ EASE**. In descending order of centralization, Atlantic County (609/645-7700, ext. 4700) is generating an integrated model, Union County (908/527-4866, ext. 4872) offers a consolidated approach, Ocean County (908/929-2091) is collaborating with other public agencies, and Morris County (201/285-6848) is attempting a public-private partnership.

**Finding procedures of the Health Care Financing Administration too lax, federal district Judge Alfredo C. Marquez has ruled that Medicare HMOs must provide beneficiaries with timely, readable notice of all denials of reimbursement. The notice must state the reason for denial, offer a timely hearing, and tell how to obtain supporting evidence, said the Arizona-based jurist.**

Disagreeing with the ruling, Health and Human Services Secretary **Donna E. Shalala** claimed that the HMO decisions "are not government action" and so don't require due process of law. Senior groups seemed not to notice the secretary's disclaimer, which was uttered less than one week before the election. Nor do seniors appear to blame the administration for Medigap premium increases of

23 percent, which **Families USA** attributes in part to HMOs' skimming off low risks.

On January 2, the State Health Planning Board will review organ transplant certificate-of-need (CN) applications. Hospital and medical center applicants for heart transplant CNs are **Cathedral, Cooper, Hackensack, Newark Beth Israel, Our Lady of Lourdes, and Robert Wood Johnson University Hospital**. Lourdes, RWJUH, and **UMDNJ** are vying for liver transplant approval. All of these except Lourdes and NBI are in the kidney arena as well.

**New Jersey has been joined with New York State and Pennsylvania as sites for HCFA's new demonstration project, under which physician payment will be bundled with hospital payment. The idea is to save money by "aligning incentives" of physicians and hospitals. Several New Jersey hospitals appear interested in applying to participate, but in some cases the medical staffs are wary.**

A challenge to both groups, the "per-case" demonstration is about to unfold through a request for letters of intent. Project designers have visited both the **New Jersey Hospital Association** and MSNJ, even before traveling to the other states, to discuss plans. Although physician resistance is strong, there may be wisdom in physician participation in Medicare cost-control initiatives; controls are inevitable due to demography alone. In the final analysis, this is about aging—the very product of "wellness," public health, and quality health care.

**Neil E. Weisfeld**



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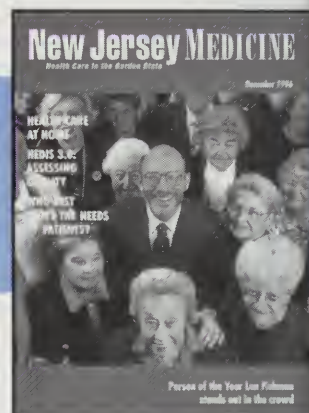
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The 1996 Person of the Year is Commissioner of Health and Senior Services Len Fishman. New Jersey MEDICINE recognizes Commissioner Fishman as the person who has effected the greatest change in 1996 in health care and health care policy in the Garden State. Cover: Conrad Gloos

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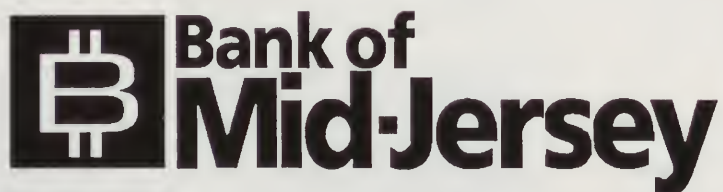
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# New Jersey MEDICINE

## Great laser debate

I have read with interest the article in the September 1996 issue of *New Jersey MEDICINE* entitled, "Ophthalmologists and optometrists: Who should use a new laser procedure?" A similar controversy has developed in the field of laser treatment for snoring and sleep apnea.

With the advent of in-office laser equipment, first otolaryngologists and now oral surgeons and some general physicians have purchased laser devices to treat snoring and, inappropriately, sleep apnea.

Managed care programs saw this as a great potential for overutilization and their approach was to deny or deeply decrease reimbursement for virtually all sleep diagnostic services. This, of course, has decreased cost but with the equivalent of throwing out the baby with the bath water.

I would like to point out that laser-assisted uvulopalatoplasty is extremely important and I would strongly suggest *New Jersey MEDICINE* review this entire topic as another "great laser debate."

John Penek, MD

## A good cigar is an oxymoron

Cigar smoking has been made popular and is on the increase due to lack of negative advertising, celebrities smoking in public, and advertising that makes it appear glamorous, sexy, and fun.

The misconception that this form of tobacco is safe must be reversed at all possible opportunities.

I urge all members of the medical profession to educate their patients to the following facts from the American Cancer Society.

- The carcinogens and cancer-producing chemicals found in cigarettes also are found in cigars (US DHEW 1979).
- All tobacco users are five to ten times more likely to get cancer of the mouth or throat than nonsmokers (*Washington Post*, 1/10/95, p. 7).
- Cancer death rates among men who smoke cigars are 34 percent higher than among nonsmokers (*Newsday*, 12/18/95, p. B4).

- Cigar smokers have four to ten times the risk of dying from laryngeal, oral, and esophageal cancers as non-smokers (*Eur J Cancer*, 29:763-766, 1993).

- Cigar smokers have a three time higher rate of lung cancer than nonsmokers (*J NCI*, 73:377, 1985).

- Cigar smokers are more likely than nonsmokers to suffer from persistent coughs and phlegm, and also face an increased risk of peptic ulcers (*Am J Pub Health*, 11/87, p. 1412-1416).

- Exposure to secondhand cigar smoke carries the same risks as exposure to second-hand cigarette smoke (*Washington Post*, 1/10/95, p. 7).

- Tobacco users cost American taxpayers \$68 billion per year in medical expenses and lost productivity (American Cancer Society, *Facts and Figures*, 1995, p. 22).

Douglas Lee Chester, DDS,  
Commission on  
Smoking OR Health



## Requirements for letters

To submit a letter, FAX (609/896-1368) or mail a copy of your letter to *New Jersey MEDICINE*, Two Princess Road, Lawrenceville NJ 08648. Letters should be typed and double-spaced and should be no longer than 400 words with up to 4 references, if necessary. Include your full name, affiliation, address, and telephone number.

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Neil Levin, DO

## Levin wins award

University Medical Center awarded **Neil Levin, DO**, the annual Medical Staff Leadership Award. Dr. Levin is honored for his outstanding performance, commitment to Kennedy, and involvement in hospital and community programs. Dr. Levin is a family practitioner with CareSource Medical Associates, the Kennedy system's primary care group practice.



Scott Alan Ames, MD

## Ames is new director

Newark Beth Israel Medical Center has named **Scott Alan Ames, MD**, director of renal transplantation. Prior to his appointment at Newark Beth, Dr. Ames was the medical director of University Medical Center Transplantation Services and medical co-director of the Nevada Donor Network, both in Las Vegas.

## Home health aides recognized

Home health aides from across the Garden State were given recognition for their dedication and hard work at the annual Home Health Aide Recognition Luncheon. Honorees were presented a certificate of appreciation and a recognition pin. The luncheon was sponsored by the Home Health Assembly of New Jersey (HHANJ), the Garden State's largest and most

comprehensive professional home care association representing over 130 home health care providers across the Garden State. **Carol J. Kientz, RN**, is the executive director of HHANJ and a member of the *New Jersey MEDICINE* Review Board.



Carol J. Kientz, RN

## Making a difference for medicine

**Alexander Axelrad, MD**, has been named assistant trauma director for Atlantic City Medical Center, a division of the Atlantic-Care Health System.



Alexander Axelrad, MD

Governor Christie Todd Whitman appointed **Terri L. Freeman** to serve on the UMDNJ Board of Trustees and **Cheryl J. Tice** to serve on the New Jersey Advisory Commission on the Status of Women, which supports the needs of

women in health care, legal rights, education, and political and economic quality.

**James Henry** has been appointed Administrative Director of Emergency Services and **Ted Kanarek** has been appointed Operations Manager, both at Union Hospital, which is affiliated with Saint Barnabas Health Care System.

Under the medical directorship of **Arthur Krosnick, MD**, the **Mercer Medical Wound Care Center®**, in Trenton, has achieved the highest current healing rate—94.3 percent—among wound care centers nationwide. The Mercer County center is dedicated to



Arthur Krosnick, MD

the treatment of chronic, nonhealing wounds and has treated almost 2,000 patients since opening in 1991.

## Lourdes I.

### Montes, MD,

has joined the Monmouth Medical Center as the second full-time diagnostic radiologist specializing in breast imaging at The Jacqueline M. Wilentz Comprehensive Breast Center.



Lourdes I. Montes, MD

*continued on page 12*

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*Craig N. Piso, PhD*

**Craig N. Piso, PhD**, comes to Saint Barnabas Health Care System as vice-president of Behavioral Health Services for the Saint Barnabas Behavioral Health Network.



*Branka Ford, MD*

**Branka Ford, MD**, joined the Robert Wood Johnson Medical Associates at Hamilton. Joining the Robert Wood Johnson Univer-



*Victor D. Iturbides, MD*

sity Hospital at Hamilton is **Victor D. Iturbides, MD**. Passaic Beth Israel Hospital welcomes pathologist **Farhas Setoodeh, MD**, to the medical staff.



*Farhas Setoodeh, MD*

He comes to Passaic Beth from Roche Biomedical Laboratories, where he was director of laboratories. Setoodeh



*Harry C. Boghigian*

is charged with developing the special service of hematopathology and enhancing the practice of cytopathology at Passaic Beth.

**Harry C. Boghigian** has been appointed to the position of vice-president of marketing at Roche Laboratories, Inc., in Nutley, the pharmaceutical marketing and sales subsidiary of Hoffman-La Roche, Inc.

## Remembrances of leaders of the Medical Society of New Jersey

MSNJ's past-president **John S. Madara, MD**, passed away on October 4, 1996. Highly regarded by his peers and the community, Dr. Madara practiced in Salem County for many years, serving as the first medical director of The Memorial Hospital of Salem County; hosting a weekly radio show; and volunteering at medical clinics.

Dr. Madara served MSNJ as an alternate delegate to the House of Delegates and on the Council on Communications and the Council on Biomedical Ethics. He was past-president of the Salem County Medical Society. His commendations include the United Fund's President's Award, the MSNJ's Golden Merit Award, the Boy Scouts of America's Good Scout of the Year Award, and Salem's Citizen of the Year.



*John S. Madara, MD*


Family practitioner **Frederick W. Durham, MD**, passed away on September 25, 1996. A long-time member of MSNJ, Dr. Dunham is best remembered by his involvement with the Judicial Council, serving as chair from 1983 to 1987, and as a delegate to the AMA. He also served as president of the Camden County Medical Society.

Dr. Durham was born in Camden. He practiced in Haddonfield for many years and was medical director of the Haddonfield Ambulance Association. Dr. Durham's affiliations included The Academy of Medicine of New Jersey and the American Heart Association. He was affiliated with Cooper Medical Center and West Jersey Hospital, Marlton. Dr. Durham was awarded MSNJ's Golden Merit Award in 1995.



*Frederick W. Durham, MD*

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## Advisory commission formed

President Clinton announced the formation of the **President's Advisory Commission on Consumer Protection and Quality in Health Care Industry**—parallel to the AMA's agenda to heighten governmental awareness of the need for patient protections in managed care. The Commission will assess changes occurring in the health care system and recommend measures to promote quality and value and to protect consumers.

## Thanks for Giving Ball honors physician

Lincroft resident **John W. Sensakovic, MD, PhD**, was honored at the 23rd Thanks for Giving Ball sponsored by Saint Michael's Medical Center, in Newark. The Thanks for Giving Ball is held annually to raise funds for a designated project at Saint Michael's. This year's proceeds will be used for the enhance-



John W. Sensakovic,  
MD, PhD

ment of information systems at the Newark medical center.

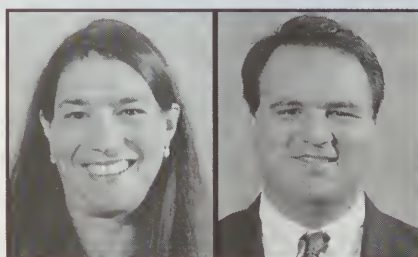
Dr. Sensakovic is the corporate director of medical education and director of the nosocomial disease laboratory at Saint Michael's; medical director of the Physicians' Assistant Program at Seton Hall and UMDNJ; director/

chair of the infection control department at John F. Kennedy Medical Center, in Edison; and bio-clinical laboratory director at Alden Bio-Clinical Laboratory, in New Brunswick. Dr. Sensakovic is professor at Seton Hall University School of Graduate Medical Education. He served as a consultant to the MSNJ Committee on AIDS.

## Names making the news in health care

**Audrey Tashjian, MD**, and **William Parks Stanell, MD**, joined Trenton's Mercer Medical Center medical staff in the department of obstetrics and gynecology. Both physicians will be practicing in Lawrenceville.


**Jersey Shore Medical Center**, in Neptune, **Riverview Medical Center**, in Red Bank, and the **Medical**



Audrey Tashjian,  
MD

William Parks  
Stanell, MD

**Center of Ocean County**, in Point Pleasant and Brick are preparing to merge after receiv-

ing confirmation from the Federal Trade Commission. John K. Lloyd, currently the president of Jersey Shore Medical Center, will serve as president of the new group. "This partnership among our three institutions will make our integrated health system a leader in the delivery of quality health care," said Mr. Lloyd. 

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The American College of Occupational and Environmental Medicine has issued **"Pearls" of the Specialty**, edited by Dr. William Greaves. This book is a compendium of brief vignettes on managing and preventing disorders unique to occupational and environmental medicine. Nearly 20 professionals from academia, industry, consulting groups, and private practice contributed to this book. To order a copy call, 800/533-8046.

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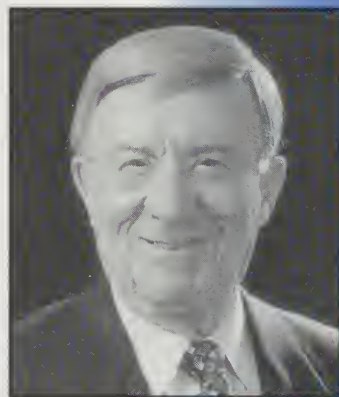
Good-bye Big C. You may never have to fear cancer again; a protein found in mother's milk will protect you. Never get depressed again or even blue; an ancient cure-all from the sea will make you feel good all the time. Bioflavonoids from pine trees and grape seeds, combined with aloe vera, can slow the aging process, combat degenerative diseases, reverse atherosclerosis, and control diabetes—all with a full one-year guarantee. And on and on.

Those of us trained in the scientific method have great skepticism about such claims. But millions of people worldwide are willing to pay for alternatives to conventional medical care. Professor Michael Baum, surgeon at the University College London Medical School, London, England, authored an 'A to Z' list of unproved methods of cancer diagnosis and treatment in the October 1996 issue of the *Journal of the Royal Society of Medicine*. They are: aromatherapy or acupuncture; Bach's flower remedy; crystal healing (and others); dousing; vitamin E and electroacupuncture; faith healing and fire walking; Gerson therapy; herbalism and homeopathy; iscador and iridology; Johnson's remedy; krebiozen; laetrile; moxibustion; negative ionizers; orgone accumulators and organic diet; psychic surgery, pyramidology and others; quinine; radionics and reflexology; Simonton's cure; theosophy and trepanation; urine therapy; vrilium tubes and vegatest; water remedy; xanthine remedy; yoga; zebethium occidentale; and more.

*Those of us  
trained in  
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great  
skepticism  
about  
alternative  
medical  
claims.*

Although Baum, well-known in breast cancer circles, was discussing cancer treatment, the alternative measures he listed also are promoted for other conditions. And that adds to the problem, which is complicated by trying to distinguish between conventional, alternative, and natural medicine. The argument is given that conventional techniques are indicated for trauma, emergencies, prematurity, infection, and rehabilitative and cosmetic surgery, but fail in controlling chronic, degenerative woes (heart disease, stroke, and cancer), and stress-related infirmities—from asthma to chronic dyspepsia.

The issue has been joined in recent months and years by the decisions of various insurers to include alternative medicine in its coverage. *The Wall Street Journal* headlined on January 30, 1995, "Health Insurers Embrace Eye-of-Newt Therapy." It referred to American Western Life Insurance Company and its 123-page handbook 'brimming with natural treatments', to Lovelace Health Systems in Albuquerque (referrals to Mexican medicine healers), and to other companies (Prudential and Mutual of Omaha) utilizing nontraditional methods. In early October 1996, Oxford Health Plans joined the growing trend and announced plans to include credentialed practitioners of such disciplines as 'naturopathic' medicine and Chinese herbology.



Howard D. Slobodien, MD



*The Lord hath created medicines out of the earth; and he that is wise will not abhor them.*

Apocrypha, Ecclesiasticus, 38:4-5.

*The desire to take medicine is perhaps the greatest feature which distinguishes man from animals.*

Sir William Osler, *Cushing's Life of Sir William Osler*, 1925.

Herbal medicine has been a continuing growth industry, and many otherwise traditional practitioners have added some of its elements to their armamentaria. This should not surprise those of us who know about foxglove, cinchona, etc., because the roots of herbal medicine go deep into antiquity. There were botanical gardens in China in 2800 BC, and Egyptian priests cultivated medicinal plants such as aloe and poppy in 1400 BC. 'Physic' gardens flourished during the Renaissance, initially in Italy and Germany, later in France and England, and were used for the education of medical students.

The growing use of botanicals has forced governmental action, evidenced by the establishment of the National Institutes of Health's Office of Alternative Medicine (OAM) in 1991. There are an estimated 8,000 natural health food stores in the United States, with recent sales of over \$500 million; plant-based medicines occupy an even larger part of European and Asian standard drug therapy. Regulatory problems abound. The Federal Drug Administration (FDA) is responsible for evaluating products claimed to have medicinal properties. To date, most botanicals have been exempted, although the head of the FDA's Office of Drug Evaluation and Research questions the safety of many herbal preparations. Conversely, the World Health Organization, of the United Nations, would accept the safety of plant products, unless proved otherwise. Quite a disagreement!

As the May/June issue of *Remedy* expressed it, "A century ago, snake-oil salesmen hawked their wares—magical elixirs to cure melancholy and treat baldness, secret potions to eliminate pain and cure malignancies—from

the backs of traveling wagons. These days, we like to think we're too thoroughly modern to be fooled by such nonsense. Well, think again. Medical quackery is alive and well—and women and men over 50 often are favorite targets." The magazine cites a FDA study indicating 40 million Americans wasting \$30 billion yearly. But how do we assay and control hope in a bottle?

Sandra Olson, president of the Illinois State Medical Society, noted, in her October 1996 article in *The Medical Tribune*, the absence of any substantive studies produced by the OAM. She also noted the wave of enthusiasm for alternate medicine evinced by the 34 medical schools now offering courses on the subject. Harold J. Morowitz, Robinson professor of Biology and Natural Philosophy at George Mason University, was quoted in the November 1994 *Hospital Practice*, "Rationality has its bounds, and it is not true that anything goes. There is the innovative, the imaginative, the idiosyncratic, the ill-construed, and the insane. When one passes into the fifth i-word, the best response seems to be a gentle chuckle."

Morowitz added his name to the many who question the FDA (and OAM) efforts, or lack thereof, in guaranteeing the safety and efficacy of over-the-counter materials that claim medicinal values. The pharmacists also want some assurance, as noted by Gary Halpern in the October 1996 issue of *Pharmacoeconomics*. He said, "It was imperative that herbals be recognized for what they are, drugs, with both positive and negative effects [and that] without research, who is to say that herbal remedies are not cost effective." On the other hand, without proper research and evaluation, who is to say they are, and who is to warranty their safety?

**NJM**

## ONE ON ONE: WE NEED TO KEEP MEDICINE STRONG

*Anthony P. Caggiano, Jr, MD*

The successes of organized medicine—coupled with clinical achievements and an unparalleled scientifically based body of learning—have made the medical profession in the United States into the leading model of high political and social status for any group. Virtually all other health occupations have learned from us and listened to us—social scientists, politicians, business leaders, educators, and clergy.

Today, though, things are different. Economic pressures are forcing economies in health care, mainly because that sector has grown to the point where it accounts for one in every seven dollars spent in the United States.

And, yet, a paradoxical event is taking place in medicine. At a time when physicians should be banding together for the common good, they are divisive and nonunified. Mem-

bership in organized medicine is decreasing. The age old question, "What has organized medicine done for me lately?" is heard all over.

What is most important is that we—particularly we in New Jersey—remain united. If the profession of medicine crumbles into small interest groups aligned by specialty, geography, gender, hospital system, network, ethnic background, or other characteristics, we will lose more than we gain. Make no mistake: **division is a prescription for disaster.**

At this time in medicine when so many exogenous forces are threatening the everyday practice of good, honest physicians, we need to close ranks rather than divide ourselves over these outside issues that are destroying us.

We must get back to the way we felt about our profession and our colleagues when we were all in medical school striving for the same goal: that wonderful doctor of medicine degree we have all attained successfully.

We must stop looking at ourselves as the enemy and realize the real enemy. The enemy is outside. It is those who are concerned with the

bottom line. But those people cannot do what we do: administer safe, efficient, competent, and meaningful health care to the patient population of this country.

MSNJ has taken the leading role in keeping medicine strong. The accompanying Table 1 highlights some of MSNJ's accomplishments and victories over the past few years. MSNJ is fighting for



*Anthony P. Caggiano, Jr, MD*



**Table 1. What MSNJ has done for us lately.**

- MSNJ sponsored five professional liability bills that were signed into New Jersey law by Governor Whitman.
- MSNJ fought HMO lobbyists and won 48-hour and 72-hour maternity hospital stays.
- MSNJ is fighting for the Health Care Quality Act. MSNJ was instrumental in introducing bills at both the state and national levels.
- MSNJ reduced physician medical waste registration fees from \$428 to \$100 annually, saving physicians 10 percent increments.
- MSNJ helped defeat a 2 to 3 percent gross tax on physician revenues.
- MSNJ managed a spectacular override vote of the governor's veto to repeal a 2.5 percent Joint Underwriting Association surcharge.
- MSNJ won a reduction in the surcharge malpractice recovery fund from 5 to 2.5 percent.
- MSNJ won Caller ID Block for physicians' home telephones.
- MSNJ won a suit against the state Board of Medical Examiners on deleting confidential, personal, and private information on licensure application forms.
- MSNJ set up a voluntary Medical Courtesy Card Program to assist needy elderly without government interference.
- MSNJ secured significant changes in Medicare policy in fee and coding disputes and restored payment for consultation prior to surgery.
- MSNJ helped to create the best run professional liability carrier in the country.
- MSNJ successfully defeated an action wherein physical therapists introduced a bill to prohibit physicians from hiring physical therapists.
- MSNJ publishes the award-winning *New Jersey MEDICINE*, the health care and health policy magazine for professionals in the state.

more effective and necessary controls on HMOs. As a result, we in New Jersey will not need a prohibition on gag clauses that Congress failed to enact. We were first with a law prohibiting "drive-through" deliveries. We have worked successfully with our legislators and regulators to reduce hassles with medical waste management and repeal unfair malpractice surcharges that afflict our neighbors in Pennsylvania. We have managed to stave off a ban on balanced billing. In contrast to what happened in Tennessee and other states, our suggestions for quality assurance were accepted by the new Medicaid managed care program. We have mounted programs that are second to none in biomedical ethics, public health—especially tobacco control—endorsed services, and health insurance. MSNJ has been a strong and leading voice on the advisory panel for HMO regulations that have not been revised in over 22 years.

So, membership is the issue at hand. Every physician practicing in the state of New Jersey has benefited immensely as a result of MSNJ's efforts—members and nonmembers. We

*"No one cares how much you know until they know how much you care." This is the way people need to look at physicians and what they do for patients.*

who are dues-paying members should call on our reluctant and apathetic colleagues to pay their fair share. Our membership services, our legislative efforts, and our regulatory surveillance permit each of our members to practice a bit more comfortably in this new, and sometimes hostile, climate. MSNJ is at the forefront, battling insurance companies and managed care abuses of patients and physicians.


Now is the time when membership in organized medicine must begin to increase. I would like to propose what I feel is a relatively simple and effective method of increasing our membership (Table 2). I want each member of MSNJ to target one of their nonmember colleagues. I want each member to vigorously, energetically, and enthusiastically approach those nonmembers and recite the litany of reasons for joining MSNJ and organized medicine. I want members to be persistent in this quest. Do not take no for an answer!

At present, we are reducing fees for new members. We have streamlined our membership application and review process. We have produced new materials to help you persuade nonmember colleagues to join MSNJ.

We have to fight back and MSNJ clearly is the best equipped, most prestigious, and best positioned arsenal available to us or to any group in New Jersey.

I need your help as we reach out for new members so that we can build on our accomplishments. Contact your county medical society and ask for assistance in recruiting members. Consider becoming more active, and look into opportunities to serve on a committee to make your views heard.

MSNJ is a state medical society with a national reputation for efficiency, effectiveness, and dedication. It is a medical society that is up to date, creative, and vigorous. It is your medical society.

**Dr. Caggiano is  
the president of**  **MSNJ.**

## **Table 2. MSNJ Board of Trustees recommendations**

- Recruitment and retention are the top priorities for MSNJ in 1997.
- The goal is a net increase of 300 new members.
- Each Board member will recruit 3 new members.
- President's Award of \$1,000 to the county medical society with the highest percentage net increase in membership in 1997.
- \$100 incentive is available to county medical societies for each new member that represents a net increase.
- \$5,000 recruitment grant program providing \$1,000 awards to county medical societies for innovative recruitment activities.



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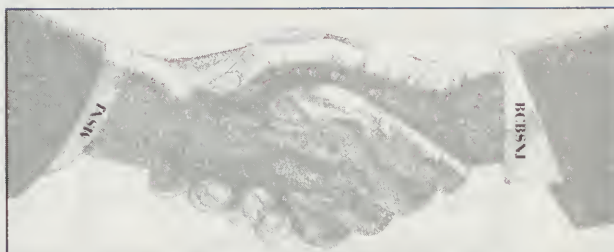
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Bill Berlin, PhD

## PERSON OF THE YEAR: COMMISSIONER LEN FISHMAN

**With this issue, New Jersey MEDICINE inaugurates our Person of the Year award in recognition of the year's top health care newsmaker in the state. Our first honoree is Len Fishman, commissioner of Health and Senior Services, who has had a significant impact on New Jersey health care.**

- *His leadership in reshaping state HMO regulations, making them, in the words of one observer, "far and above anything done anywhere else in the country."*

- *His success in consolidating all programs and funding for older adults in the new Department of Health and Senior Services.*

- *His efforts to effect a responsible resolution to the charity care problem.*

- *His guidance of hospital regulatory reform.*

- *His strong commitment to public health, including tobacco control and AIDS awareness.*

Beyond his accomplishments, Len Fishman has earned broad praise as a man who cares, listens, and responds. The first nonphysician to serve as commissioner of Health and Senior Services, Fishman has received high marks from leaders of the medical sector for his commitment to patients and practitioners. "He is one of the most engaging, competent, and open commissioners we've ever had," says Vincent Maressa, executive director of MSNJ.

Maressa's comments are echoed by many admirers outside the health care sector. "Len is an absolutely wonderful and remarkable person," says Neil Upmeyer, editor of New Jersey Reporter magazine. "In an administration in which the reins are tightly held by the governor, Len is refreshingly forthcoming, insightful, and direct." Indeed, Upmeyer credits the commissioner with persuading Governor Whitman to support a tax hike on tobacco products despite the political risks involved.

Len Fishman was born in Baltimore in 1951. He is a graduate of Antioch College and the University of Maryland School of Law. Before joining the Whitman administration, he was general counsel to the New Jersey Association of Non-Profit Homes for the Aging, where he was responsible for policy development and legal and regulatory affairs. He also served as co-chair of the Governor's Health Care Transition team.

Fishman brings to his position a consensual style and a flexible approach to government. He likes to bring all parties to the table, draw upon both public and private expertise, and hammer out pragmatic solutions. "What used to frustrate the hell out of me when I was on the other side of the table was when government defended what it was doing almost in a blind fashion," Fishman notes. "This situation reminds me of the old story about the willow and the



oak. If you are willing to make changes and bend, the core of what you're trying to protect is more likely to survive."

Some of his admirers say that the commissioner is being forced to bend too much by an administration inclined toward budget cutting and excessive deregulation. George Laufenberg, administrative manager of the New Jersey Carpenters Funds, believes that Fishman is doing a "reasonably good job" at a time when the state is backing away from health planning and restricting department budgets. Another long-time observer of state government fears that Fishman is being hamstrung by "agents from the front office," more concerned with political accommodations than with real solutions to changes in health care.

Nevertheless, in discussing the future, Len Fishman sounds like an activist, stressing greater coordination of senior services, expansion of the state's health information system, stronger efforts to prevent youth addiction, and further extension of health care resources to minority populations.

The commissioner's role model is Abraham Lincoln, whose picture hangs next to the doorway of his office, and whose name was given to his son. Lincoln presided over a

period of great change and turbulence. He brought to his tenure a commitment to unity, justice, and compassion—good qualities in a president or, for that matter, in a commissioner of Health and Senior Services during a time of uproar and confusion in health care.

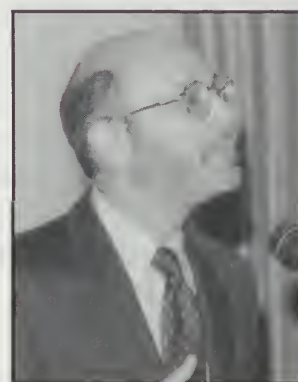


**Q.** You have presided over the Department of Health and Senior Services during a time of possibly the greatest historical changes in health care in New Jersey. Would you agree with that assessment?

**A.** Yes. We're living through a time of unparalleled change on so many fronts. Changes are being contemplated in Washington, DC. We've seen the end of hospital rate-setting and the growth of integrated delivery systems in New Jersey, as well

as the movement of the Medicaid AFDC population into managed care. We also see the increasing importance of information technology.

But the biggest change of all is the explosive growth of managed care. In 1975, only



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5,000 people were enrolled in HMOs in New Jersey. Today, that number surpasses 1.9 million, and it's growing. One in four New Jersey residents is enrolled in an HMO, and HMOs represent only one-half of those enrolled in some type of managed care. This represents a sea change in health care in the state.

**Q.** How do you view the role of the commissioner in terms of this "sea change"?

**A.** To keep our health care system patient centered and to preserve the physician-patient

relationship while allowing managed care to proceed is my view. To a lot of people these goals may seem contradictory, but there are ways to advance them all. An important example is the consumer protections that are



part of our proposed HMO regulations. They provide appeal rights for patients and providers acting on their behalf. They require utilization management decisions be made only by physicians. They assure consumers a choice of primary care physicians and specialists. They prohibit the so-called "gag rule."

But absolutely essential to these regulations is the use of outcome measures, both population based and patient centered, which I think represents the next generation

of health care regulation. We've gone further than any state in the country in proposing outcome measures as a way of determining whether HMOs are making good on their promise of providing high-quality



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preventive and primary care in addition to specialized care.

We have a three-year work plan for outcome and process measures. We will start with data that should be fairly easy for HMOs to report, such as number of children immunized and the number of women screened for breast and cervical cancers. Patient-centered measures focus on items like whether pregnant women receive prenatal care in their first trimester, whether patients with diabetes receive a retinal examination, and

whether patients with asthma are successfully managed in a hospital or outpatient setting. In the second and third years, we will be more ambitious, eventually looking at the outcome of selected surgical procedures and whether breast cancer is being detected at an early stage.

We also will be doing a consumer satisfaction survey. We will be using a uniform instrument across all 26 HMOs in this state to get patient feedback on the kinds of care they are receiving. We will be asking questions like: How long did you have to wait to see a physician? Did you have a hard time getting a referral to a specialist? Do you have enough time to talk to your physician and other health care providers?

**Q.** Paul Langevin of the New Jersey HMO Association has criticized your proposed HMO regulations precisely on these grounds. He argues that these measures should be applied across-the-board, to fee-for-service and other non-HMO providers as well.



**A.** Well, I would agree in part and disagree in part. To some extent, managed care suffers from comparison to a mythical past that never existed. There are problems with the fee-for-service system, too. So I think that it's fair for managed care organizations to say that if we are going to look at how well they are doing in terms of immunizations or breast cancer screening, we should also look at the non-managed care sector. The truth is that one of the advantages of managed care is that it's easier to manage their performance and hold them accountable.

But here's the fundamental difference brought about by managed care. In the fee-for-service system, care is patient and physician directed. Patients and their providers have great choice. When a patient's care is managed—when choice is restricted—a patient needs more information about quality and more protection in case the choices made for the patient are not appropriate.

**Q.** You raise another interesting point. It seems to me that under both systems—fee-for-service and managed care—we're still operating in an environment where there is an imbalance between the provider and the patient in terms of authority, knowledge, and influence. Are you really talking about empowering the patient through all these measures?

**A.** Absolutely. Managed care has made us look at how the patient gets information and how patients and employers find out about the quality of their health care plan. Giving patients outcome measures, membership satisfaction surveys, and an appeals process are all intended to empower patients. Another challenge is how to keep patients and health care providers at the center of emerging health information networks.

We now have an electronic birth certificate system that is operating in every hospital in New Jersey. We're the first state in the nation to have that system, and it gives us critical

information daily about birthweight, birth defects, rates of C-sections, and length of stay. This will eventually dovetail with our statewide immunization registry. By the end of this year, we will have a fully electronic statewide cancer registry. These are tremendous advances in a health information network that will someday connect all the players in the health care system, including consumers. This should lead to real improvements in the quality of care and in the empowerment of patients.

**Q.** There are people who say that Len Fishman is doing a great job, but that he must be a very frustrated guy because of financial and political constraints. What do you say to that?

**A.** I do get frustrated but not for those reasons. Constraints do create opportunities. For one thing, few people are blindly defending the status quo. From Medicare to managed care, people are opening up to change. If you consider the changes we've been able to

initiate in the last three years, they have been quite impressive. I see more opportunity for change. I think a very important aspect of my role is to build consensus, to bring in the expertise that exists outside the department, and to bring everyone to the table. A good example is the new HMO regulations, which took us a year to develop, which represent good policy because so many parties were involved.

**Q.** It seems that within the Whitman administration, which has very much emphasized the importance of the private sector, your department is one area in which things have not been left to vagaries of the marketplace.

**A.** I think that is true in part. You can be aggressive and an activist, but that activism can be expressed in different ways. For example, we've been increasing regulation in the area of HMOs. On the other side, our certificate of need (CN) regulations had not been overhauled in 25 years. Now

we've moved many services to expedited review. In April, I pledged I would impose a deadline on this department to review expedited CN applications within 90 days. Many people were skeptical about this—for good reason—but we've processed more than 200 CNs through expedited review, every one of them in less than 90 days. So I think what's needed is balance and common sense.

through hospital rate setting was innovative in its time but eventually outlived its usefulness. It was pretty clear that government was not good at saying "No." Hospitals, even inefficient ones, were bailed out, no matter what their problems.

So I think that deregulation has had a beneficial effect in exposing hospitals to greater competition and market forces. But, the Legislature in its



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I'm suspicious of any monolithic ideology, whether it's "big government" or pure "laissez-faire."

**Q.** Are we using deregulation to "shake out" the health care sector?

**A.** Yes, I think we are. The kind of regulation we had

wisdom recognized that if you are going to have a more competitive environment, you must have subsidies for hospitals who care for the poor and uninsured. That's why it's so important to maintain our charity care subsidy for these hospitals.



**Q.** Looking ahead, what are the primary things you want to accomplish?

**A.** I have some broad goals, and some targeted ones. Obviously, now that the governor has consolidated all services for seniors within one department, it's our job to implement the promise of

piloting an interactive system to monitor quality in nursing homes not just once a year, but continuously.

In the regulatory sphere, we are looking to implement the new HMO regulations. The next agenda item in managed care will be the need to extend regulations to non-



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consolidation. Ultimately, we want all counties to be on-line so that seniors or their families can call one number to get all the information they need about services, ranging from senior centers to Medicaid eligibility information to Meals-on-Wheels. We've made progress on long-term care options through assisted living and alternate family care. I've issued over 100 CNs to assisted living applicants. In respect to quality care, we're

HMO managed care organizations, like PPOs. I suspect that this issue will be coming in the next few months. The expansion of our Health Information Network is another big issue, especially making sure that practitioners and patients are not left out of that system.

**Q.** What about the charity care issue? We still don't have any long-term answer to that problem.

**A.** We're in the process now of designing a charity care system that uses managed care principles as the Legislature has directed. The next big issue we'll have to tackle next year is how to continue funding charity care. That's an absolutely critical job for us, because if you don't fund charity care, hospitals that are efficient and are providing essential services to the poor and uninsured will simply not be able to compete in the current environment, and that would be terrible.

**Q.** How should we fund charity care?

**A.** The last time around, the governor proposed a permanent funding mechanism that included a tax on tobacco products. The proposal was not received as enthusiastically as I had hoped. It would have been a good way of funding charity care and would have provided a great public health bonus. I think we're going to have to start from scratch next year. It's not just a matter of getting money to the hospitals that have earned it. It's about keeping in place a safety net for the state's poor and uninsured.



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# MSNJ WEBSITE SURVEY

The MSNJ Website is coming in January 1997! And, we are interested in knowing about your Internet capabilities.

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If you do not have access to the world wide web, please fill out the following survey and FAX to 609/896-1368.

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## Taking care of business ... in the home

Diane Haring Cornell

If Knight Steel, MD, were in *The Graduate*, the word he'd be whispering to Dustin Hoffman wouldn't be plastics. It would be home care.

Yes, Dr. Steel says, he's seen the future and for medicine it lies in the home-based care of patients who previously required hospitalization.

Fueled by new technology and managed care, the simple idea of a physician with his black bag making house calls has exploded into a \$30 billion industry that touches every part of medicine and patients of all ages, from premature babies to senior citizens.

According to the Center for Home Health Development, last year in New Jersey more than 6.5 million home care visits were made to nearly 170,000 residents.

Dr. Steel, a member of the Center's board and an expert on educating physicians about their role in delivering home- and community-based services, says that despite the image of doctors

making house calls, physicians have played a diminished role in home care's expansion.

"Physicians have to sign for home care services and oversee them, but in fact they do very little management in the home setting," notes Dr. Steel, director of the Homecare Institute at Hackensack University Medical Center and an endowed professor of geriatrics at UMDNJ-New Jersey Medical School.

Peter Boling, MD, president-elect of the American Academy of Home Care Physicians agrees. "Doctors do not relish the opportunity to get involved in home-based care. It's too cumbersome." Founded in 1987, the 1,500-member national Academy promotes the art, science, and practice of medicine in the home.

Dr. Boling, an associate professor of internal medicine at the Medical College of Virginia, directs a team of physicians and nurse practitioners who make 2,000 house calls a year to 150 patients.

"Many doctors are not very comfortable with home care—especially as it becomes more

technically sophisticated," Dr. Boling says. "Often they are not trained in it and medical schools tend to ignore the area.

"Most physicians view it as a hassle because of the forms and papers to fill out and telephone calls and documentation. Physicians resent the demand on their time because they are not being adequately compensated. Usually physicians are paid on a fee-for-service basis. But home care almost is all telephone work. Up until this year there was no payment for oversight of these cases."

Now physicians receive \$65 to \$70 for 30 minutes or more per month of what is termed "skilled medical management," such as reviewing laboratory results or consulting with the agency that gives direct care. The allotted time does not include time spent talking with the family or the patient.

"In addition, the physician must document all the bits and pieces that make up the half hour," Dr. Boling relates. "All of which means that it is less hassle to see patients in your office for a half hour and make a small



notation in a chart than it is to do all the paperwork involved in home-based care. The process of doing the work is a lot easier in office-based care."

Although physicians may look at home care as an inefficient way to deliver care, seeing it as costly, time consuming, and inconvenient, the changing realities of health care will force them to become home care providers.

As the population ages and pressures mount to shorten hospital stays and provide more cost-effective care, and as acute diseases become chronic illnesses, home care will have ever-growing importance.

Dr. Steel predicts that in the next five years home care will be bundled with acute and chronic care in the hospital, thereby forcing all of medicine to take a crash course in dealing with home care issues.

"Physicians are going to be required to do home care whether they like it or not," Steel says. "Physicians are all going to have to get over the concept of site-specific care and do more person-specific care from now on."

Disciplines ordering home care most often are internal medicine, family practice, and geriatrics because they are involved in the treatment of chronic illness, followed closely by pediatrics, surgery, and neurology—areas that deal with post-acute illness.

But Dr. Steel says all areas of medicine will have to know about home care, "Even a thoracic surgeon will have to know about home care services, because insurers now want to have a patient discharged 72 hours after a coronary bypass. Protocols are being developed that go across boundaries of care."

Many doctors argue that home care is not the best system for delivery of care to these patients—

because most case management is done over the telephone. They contend that patients with similar illnesses would normally be seen in a hospital.

Janet M. Lieto, DO, geriatrician and assistant professor of clinical family medicine at UMDNJ-School of Osteopathic Medicine, responds that many physicians are unaware of what now can be done in a home setting.

"Almost all the tests and services performed in the hospital can be done in the home," she says, citing portable EKGs, ultrasounds, intravenous infusion, chest x-rays, echocardiograms, and laboratory testing as examples.



*Janet M. Lieto, DO, gathers her paperwork and records in preparation for a house call.*  
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*Stuart T. Lewis, DO, a geriatric fellow, and Dr. Lieto discuss care with Barbara Ballard.*  
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Her program currently makes housecalls to 120 homebound patients, the majority with chronic obstructive pulmonary disease, stroke, and end-stage dementia. "Patients with chronic problems may get complications," Dr. Lieto comments. "Physician home visits diagnose new problems and enable interventions to keep elderly homebound patients healthy and functioning to their capacity."

The program covers almost all of Camden County and parts of Gloucester County. The farthest patient lives 45 minutes travelling distance away from the Stratford school. The average amount of time spent in home care for these patients varies from about one to two years. Dr. Lieto has had one patient for six

years, ever since she did her geriatric fellowship at the school.

"The one big thing on a visit is to find out how the caregiver is doing and if there are any other resources in the county they can tap," she says. "An average visit, including travel time, takes about one hour."

Dr. Lieto has one caregiver, an 80-year-old woman who is caring for her 85-year-old, demented, bed-bound husband. The wife has to feed him, diaper him, and move him, lifting him from the bed. Unbelievably, this woman is coping, says Dr. Lieto,



*Dr. Lieto completes her examination of a homebound patient, George Washington.*  
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*Drs. Lieto and Lewis leave the home of Mr. Washington after a house call.*  
© Conrad Gloos

commenting that caregivers, be they spouses or children, have difficulty meeting the demands placed on them. "When parents become incontinent and can't remember family members, it is hard for the caregivers to continue to provide care. While encouraging patients to stay at home, you must recognize when the caregiver no longer is able to provide adequate care and be able to discuss viable alternatives."

But simply finding out resources for caregivers can be a challenge to a home care physician. "Home care is an underground part of medicine. Physicians are not well informed about different programs. Once Medicaid services are exhausted, there may be other county or community programs that can be pieced together to keep some services in the home. Home care services are so fragmented, there is no one central place that a physician can contact to

access all these services and programs," says Dr. Lieto.

Although Dr. Lieto maintains she loves what she does and finds going out on house calls fulfilling and the patients extremely grateful for her care, even she admits that it would be hard for someone to do this as a regular part of private practice.

Yet she has trouble understanding how a physician could abandon a long-time patient who is suddenly homebound. "People who have been your patients for 10, 20, 30 years—doctors should feel some responsibility to continue their care," she says. At the very least, Dr. Lieto says, physicians should become familiar with the services provided by their local Office on Aging so that they may appropriately direct their patients.

For her part, Dr. Lieto says she would like to expand her institution's residency training

programs. "I feel that making home visits part of residency programs would teach residents how to manage homebound patients and influence incorporating home care into their future practices."

What will it take to achieve the support of physicians? Dr. Steel says the home care industry clearly needs more controlled studies and a broader science base to change the undesirable view some people have of home care and begin to focus on the comfort of patients. He urges his colleagues to take a more active role in shaping home care. "We need more physicians involved, not less," he says.

And though many people may not want to hear what he says, Dr. Steel reminds us, "We need to provide care in the place most people want to be in and are most comfortable—their own homes."

**NJM**



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## IS VIDEO-ASSISTED THORACIC SURGERY COST EFFECTIVE?

**The authors are affiliated with UMDNJ-Robert Wood Johnson Medical School, University Thoracic Surgical Service, St. Peter's Medical Center, and Robert Wood Johnson University Hospital, all in New Brunswick.**

Advantages are becoming evident as video-assisted thoracic surgery non-rib spread (VATS(n)) slowly and progressively evolves.<sup>1,3</sup>

In this era of cost containment and managed care, it seemed reasonable to anticipate that a reduction in medical charges could be one of the benefits of VATS(n). Contrary to this type of thinking, a recent report found no significant difference in charges between VATS(n) and the traditional thoracotomy for lung biopsy.<sup>4</sup> To evaluate this issue, charges were reviewed and compared for groups of patients undergoing lobectomy or pneumonectomy utilizing either VATS(n) or the traditional open thoracotomy.

### *Patients and methods.*

Charges and costs are used interchangeably and indicate the bill submitted to the patient for medical services. Eight different categories of charges for 15 consecutive patients, who either had a lobectomy or pneumonectomy performed using a traditional open thoracotomy, were compared to 15 consecutive patients, who had a pneumonectomy or lobectomy utilizing VATS(n). These operations were performed in one hospital by the same operating team to attain consistency and reliability for the techniques and charges. Inflation was not a factor.

In the open group, there were seven males and eight females, ranging in age from 49 to 79 years with a mean age of 65.3 years. Eight lobectomies and seven pneumonectomies were performed for 13 carcinomas and 2 benign problems. Each of these patients had a routine hospital course consisting of acceptable, average operating room (OR) times and periods of hospitalization for this type of surgery. Seventeen consecutive patients were re-

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quired in order to acquire 15 patients, since 2 patients undergoing the traditional open technique had comorbid problems that extended the hospitalization and increased the costs above the usual averages. These 2 patients were omitted from the study.

The VATS(n) series consisted of six males and nine females ranging in age from 29 to 85 years with an average age of 64.3 years. One pneumonectomy and 14 lobectomies were performed for 15 carcinomas. Fifteen consecutive VATS(n) patients were compared to the open group. There were no omissions from the VATS(n) group despite complications and relatively prolonged hospitalizations for four patients.

The detailed financial records for all patients were carefully reviewed. Room and board, intensive care unit (ICU), medical-surgical supplies, OR, radiology, and recovery room charges were defined for individual patients and averaged for the entire group. Total length of stay, including ICU days, also was determined. The total length of



**Table 1.** Individual and average itemized charges for open lobectomy/pneumonectomy. (Miscellaneous refers to laboratory, pathology, and EKG.)

Open lobectomy/pneumonectomy										
	Total Charges	Room & Board	ICU	Med-Surg Supplies	OR	Radiol	RR	Misc	ICU	LOS
Patient O-A	12,953	3,228	4,063	1,767	1,404	901	314	1,276	3	7
Patient O-B	14,897	2,461	4,263	3,981	1,404	798	468	1,522	3	6
Patient O-C	34,923	5,649	14,210	4,822	1,931	2,571	547	5,193	10	17
Patient O-D	13,147	4,035	2,842	1,581	1,931	1,107	314	1,337	2	7
Patient O-E	17,657	4,734	5,520	2,255	1,653	1,350	759	1,386	4	10
Patient O-F	15,625	3,228	4,263	1,572	1,639	1,112	703	3,108	3	7
Patient O-G	11,320	2,421	2,842	1,606	1,703	762	314	1,672	2	5
Patient O-H	15,419	2,429	5,684	2,252	1,703	937	392	2,022	4	7
Patient O-I	19,419	3,228	7,105	2,086	1,639	1,143	392	3,826	5	9
Patient O-J	28,708	9,327	5,797	2,176	2,715	813	450	7,430	6	16
Patient O-K	11,519	2,421	2,842	1,635	1,639	726	626	1,630	2	5
Patient O-L	26,132	10,491	5,634	1,303	1,703	2,358	392	4,251	4	17
Patient O-M	12,009	4,035	1,421	2,280	1,170	762	392	1,949	1	6
Patient O-N	11,728	1,614	2,842	3,022	1,404	1,004	270	1,572	2	4
Patient O-O	16,802	4,035	4,263	3,005	1,639	1,107	180	2,573	3	8
Total Charges	262,258	63,336	75,591	35,343	25,277	17,451	6,513	38,707	54	131
Average Charges	17,484	4,222	4,906	2,356	1,685	1,163	434	2,580	4	9

stay for VATS(n) patients averaged 3.33 days versus 8.73 days for open cases. ICU days for VATS(n) averaged 0.07 days versus 3.60 days for thoracotomy cases. The cost for VATS(n) averaged \$8,660 versus \$17,484 for the open thoracotomy (Tables 1, 2, and 3).

**Results.** Utilizing VATS(n) for lobectomy and pneumonectomy instead of the open thoracotomy, charges could be reduced resulting in savings for total cost (51 percent), room

and board (29.5 percent), ICU (98 percent), medical-surgical supplies (22.5 percent), OR (19.8 percent), and radiology (45.8 percent). Interestingly, recovery room expenditures were similar. Because VATS(n) patients were being sent directly to routine floor care from the recovery room, they were held and observed for longer periods of time in this unit until they were fully recovered. However, many thoracotomy patients were able to leave the recovery room before being fully recovered

since they were transferred to the ICU.

A one-tailed null hypothesis test against the ST- $t$ -distribution was performed on the total charge data to determine the magnitude of difference between the two populations (Table 4).

The 5 percent significance level was selected, which generated a ST- $t$ -statistic of 1.701 with 28 ( $n_1 + n_2 - 2$ ) degrees of freedom. The ST- $t$ -statistic was selected because the sample sizes were of moderate

**Table 2.** Individual and average itemized charges for VATS(n) lobectomy/pneumonectomy. (Miscellaneous refers to laboratory, pathology, and EKG.)**Video-assisted lobectomy/pneumonectomy**

	Total Charges	Room & Board	ICU	Med-Surg Supplies	OR	Radiol	RR	Misc	ICU	LOS
Patient V-A	8,762	3,228	0	1,891	1,240	643	412	1,348	0	3
Patient V-B	10,969	5,600	0	1,239	1,240	507	412	1,971	0	5
Patient V-C	14,746	6,456	0	3,855	1,737	1,050	330	1,318	0	7
Patient V-D	10,083	2,421	0	3,218	1,240	594	821	1,789	0	2
Patient V-E	8,425	3,228	0	1,330	1,140	594	738	1,395	0	4
Patient V-F	5,782	1,607	0	1,416	1,140	480	284	855	0	2
Patient V-G	11,456	4,347	0	2,245	1,404	1,164	468	1,828	0	6
Patient V-H	7,483	1,614	0	2,906	1,240	396	330	997	0	2
Patient V-I	6,301	2,421	0	1,280	1,076	605	314	605	0	3
Patient V-J	6,835	1,614	0	1,829	1,170	436	468	1,318	0	2
Patient V-K	5,429	807	0	1,007	1,076	472	392	1,675	0	2
Patient V-L	9,600	3,228	1,421	1,194	2,126	678	468	485	1	5
Patient V-M	6,686	2,421	0	1,311	1,404	539	314	697	0	2
Patient V-N	8,524	3,228	0	1,692	1,404	484	626	1,090	0	2
Patient V-O	8,821	2,421	0	990	1,639	817	270	2,684	0	3
Total Charges	129,901	44,641	1,421	27,403	18,637	9,459	6,647	20,055	1	50
Average Charges	8,660	2,976	95	1,827	1,242	631	443	1,337	0.1	3.3

size. The sample standard deviation was utilized as the population standard deviations for each population were assumed unknown. The null hypothesis was the following: the cost of VATS as measured by total charges was greater than or equal to the cost of open procedures minus \$5,500. The test statistic generated was 1.718, which exceeded the ST-t statistic of 1.701 thereby supporting the rejection of the null hypothesis.

Essentially, a statistically significant rejection of this null hypothesis supports the statement that VATS cases cost at least \$5,500 less per case than open cases at the 95 percent significance level. Given the difference in mean charges of \$8,824, the statistically significant delta of \$5,500 and the distinctiveness of the charges in the two populations, the conclusion that VATS is less costly than open procedures is statistically significantly supported by the results of this study.

*Discussion.* Although there is a perceived imbalance of cases, i.e. seven pneumonectomies and 8 lobectomies in the open group versus one pneumonectomy and 14 lobectomies in the VATS group, this neither was planned nor purposeful. All consecutive open and all consecutive VATS patients from the same time frame were reviewed for this study in an attempt to make a similar comparison. These were the available cases. Some surgeons in the group strongly



*This study attempted to establish a comparison in costs between two major resectional procedures that can be performed with equal skill and facility using two different techniques.*

**Table 3.** Average charges, savings, and percent differential for VATS(n) versus open resection.

**Comparison of VATS versus Open**

	VATS	Open	Savings	(%)
Total Charges	129,901	262,258	134,325	51
Average Charges	8,660	17,484	8,955	51
Room & Board	2,976	4,222	1,246	30
ICU	95	4,906	4,811	98
Med/Surg/Supplies	1,827	2,356	529	23
Operating Room	1,352	1,685	333	20
Radiology	631	1,163	533	46
Recovery Room	443	434	9	-2
Age	64	65		
ICU Days	0.1	4	3.9	98
Length of Stay	3.3	9	5.7	63
Return to Pre-Op Activity	10	48	38	80

avored open procedures whereas others were more inclined to VATS. The operative technique was completely determined by the surgeon rather than the size of the lesion, anatomy, comorbidity, or age. Resections were performed randomly without pre-selection.

Pneumonectomy is purported to be a more complex operation requiring higher levels of intensity than a lobectomy. The General Thoracic Surgical Club, in a letter to HCFA con-

cerning pricing of pneumonectomies and lobectomies, values lobectomy at 86 percent of a pneumonectomy. If this percentage is accepted as valid and used to adjust the differences between a pneumonectomy and lobectomy and applied to this study, the cost impact is very small and remains basically unchanged. The average cost of the pneumonectomies is reduced from \$19,692 to \$16,935 changing the overall cost for the entire open group from \$17,484 to \$16,243.

If the same computations are applied to the one pneumonectomy of the VATS group, the overall charge for all VATS cases is reduced to \$8,522 from \$8,660.

If the overall work-related intensities proposed by the General Thoracic Surgical Club for pneumonectomy and lobectomy are adopted as valid, VATS still is 48 percent less costly than open major resections. This is similar to the findings recently published by Tschernko.<sup>5</sup>

Actually, this apparent imbalance of cases between the two groups can be demonstrated to be nonexistent using more definitive statistical formulae.

In the open group, there were a total of seven pneumonectomies and eight lobectomies. Average cost for pneumonectomies was \$19,692 with a standard deviation of \$8,180. The median cost was \$15,625. The minimum cost was \$11,320 and the maximum cost was \$34,923.

For lobectomy, the average cost was \$15,552 with a standard deviation of \$4,571. This

## *Charges were reviewed and compared for groups of patients undergoing lobectomy or pneumonectomy utilizing either video-assisted thoracic surgery or the traditional open thoractomy.*

is very similar to the pneumonectomies. The median cost was \$14,883. The minimum cost was \$11,519 and the maximum cost was \$26,132. A two-sample t-test assuming unequal variances, at the 95 percent confidence level, was performed generating a t-statistic of 1.10. This was not high enough to statistically suggest that the means of the populations were dif-

ferent. The proximity of the two medians supports the notion that the two populations—pneumonectomy and lobectomy—have similar cost dynamics.

In this series, the median length of stay for open lobectomy and open pneumonectomy was identical at seven days. Although there is purported to be a difference in work and resource intensities between pneumonectomy and lobectomy, this imbalance could not be distinguished by an inequality

in length of stay or dissimilarity of cost calculations between these two operative procedures.

Interestingly, the more viable and better risk patient usually was found in the open group

cially those practicing in community hospitals without house-staff, routinely admit patients to the ICU for at least one or two days. If ICU cost savings were to be omitted, there still would be cost savings from other

areas of care. VATS lobectomy patients can be safely and satisfactorily managed postoperatively by routine floor care. No intensive services are

required. Most of these patients are active on the first postoperative day and can be discharged on the second or third postoperative day. This short length of stay helps to reduce expensive services.

VATS(n) still is a new and evolving technique that requires further study, evaluation, and refinement by thoracic surgeons. Usually, it can take years of accumulated experience and meticulous preparation before basic skills necessary for the adroit performance

**Table 4.** Total charge data.

	Open	VATS
Average Charges	\$17,484	\$8,660
Standard Deviation (Sample s1, s2)	7,069	2,480
Sample Size	15	15
ST-t-statistic (@ 5%, one tailed and 28df)	1.701	
Calculated Statistic (VATS vs. Open)	4.56	
Calculated Statistic (VATS vs. [Open—\$5,500])	1.718	

since the patient more easily could endure an open procedure. Several patients in the VATS group were elderly with comorbid conditions and had been rejected for an open thoracotomy at other institutions. They were referred specifically for a VATS lobectomy.

Although cost savings resulted from decreased ICU days in the VATS group, there were cost savings from reductions in room and board, OR, medical-surgical supplies, and radiology. Many thoracic surgeons, espe-



*The operative technique was completely determined by the surgeon rather than the size of the lesion, anatomy, comorbidity, or age. Resections were performed randomly without preselection.*

of any new procedure are acquired and mastered. In fact, when the surgeon still is climbing the learning curve, any attempt at an early comparison of an evolving surgical technique, that still is undergoing refinement, to a traditional conventional operation, for which the surgeon already has developed superior skills and extensive experience, could be statistically inappropriate.<sup>6</sup> However, even at this early stage of evolution, VATS is beginning to demonstrate cost savings when compared to traditional surgery.

During the various learning phases of VATS(n), surgeons, assistants, OR staffs, anesthesiologists, and technicians all proceed in an apprehensive, cautious, and even redundant manner. Loss of the ability to palpate anatomic structures, having to develop new and different skills for hand-eye coordination, a lack of appropriate instrumentation, the need for the placement of new, smaller incisions, and a series of unfamiliar and variable anatomical approaches are just a few of the elements of this new technique making it initially confus-

ing, time consuming, and even frustrating. A nonsynchronized surgical team, malfunction of the double lumen tube or video monitor, less than optimal selection and utilization of expensive instrumentation, and general unfamiliarity with the technique can all add to the OR time and cost. Only after the procedure has been performed hundreds of times, the essentials of the operation are understood and mastered, and the surgical team is skillfully trained can the cost be accurately and validly calculated. Normal learning curve dynamics should be expected and any judgment regarding VATS should be reserved until proficiency is attained.

VATS(n) is not merely a series of smaller incisions but seems to be a less traumatic procedure that probably diminishes some catabolic changes that are not yet fully understood.<sup>7</sup> If a rib spreader is used with VATS, the procedure becomes a mini-thoracotomy with all of the resultant sequelae of a full open procedure. In that situation, surgeons are comparing a VATS-mini-thoracotomy-lobectomy to a full thoracotomy-lobec-

tomy. An accurate evaluation of VATS(n) probably cannot be derived from that type of a comparison. In our experience of seven years and more than 1,000 VATS procedures, we are beginning to confirm that many patients will have less pain, shorter hospitalizations, quicker recovery times, and decreased costs when compared to a similar series of patients having traditional open surgery.<sup>5,8</sup>

Our two series of patients in this study were operated on by the same surgeons and surgical team in the same hospital during the same period of time. A major effort was made to try to attain consistency, uniformity, and reliability between both series to develop as accurate a comparison as possible. At that time, some members of our group still were critical of VATS(n) lobectomy and performed only the traditional open lobectomy. Currently, all members of the group now favor VATS(n) lobectomy and perform it as the procedure of choice. Most of the patients in the open series had uncomplicated resections and some were discharged as early as

*VATS(n) is a new technique that requires further study and evaluation by thoracic surgeons. However, VATS(n) is beginning to demonstrate cost savings when compared to traditional surgery.*

postoperative day 4. This study probably favored open surgery since any patient with an above average stay in that category was excluded. Every patient having a VATS(n) lobectomy, despite longer than average hospitalizations, was included. This small inequity, favoring open traditional cases, did not alter the cost savings for VATS.

A shortened OR time, two- to three-day hospitalization and a potential seven- to ten-day return to preoperative status, possibly could make VATS(n) lobectomy, with complete nodal evaluation of all stations, another option for select patients needing a pulmonary resection. During the past four years, we have carefully studied, evaluated, and compared this technique to the open, traditional, isolation-ligation technique for clinical benefits, oncological advantages, and cost effectiveness. Two hundred VATS(n) lobectomies have been performed, and the therapeutic outcomes (survival) for all of the patients with carcinoma of the lung seem to parallel that of patients undergoing the open,

traditional, isolation-ligation procedure. In this study, we have attempted to establish a comparison in costs between two major resectional procedures that we believe we can perform with equal skill and facility using two different techniques. Therapeutically and oncologically, no differences have been delineated, however, VATS(n) seems to be more cost effective than the open isolation-ligation procedure for the same pulmonary resections evaluated in this series.

*Conclusion.* Although this is a small series, initial results suggest a cost advantage when utilizing VATS for pulmonary resections. Further experience will be necessary to confirm these early findings.

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## NATHAN DAVIS AND MEDICINE'S MOVE FROM TRADE TO PROFESSION

Leah Ziskin, MD  
Donna Mancuso

**The authors are affiliated with the New Jersey Department of Health and Senior Services, where Dr. Ziskin is deputy commissioner of Public Health Services. Dr. Ziskin received the 1995 American Medical Association's Nathan Davis Award.**

These are tough times for our nation's doctors. Many feel disenfranchised as managed care organizations eclipse traditional fee-for-service plans. Many doctors see these organizations, with their attention to holding down costs, challenging their autonomy and restricting their ability to practice. They feel HMOs and other managed care organizations are chipping away at medicine's dominion.

The respect and power doctors enjoy today are the results of hard-fought reform efforts that took nearly a century. One of those reformers was Nathan S. Davis, MD, the founder of the American Medical Association.

Davis and other like-minded reformers transformed American medicine from a rag-tag

collection of tradesmen and charlatans into a respected profession. They accomplished that by pushing for higher standards in American medical education, a separate, independent licensing system, and a national organization and journal for physicians.

Though the issues in American medicine today are very different than they were in Davis's time, his work still serves as inspiration. Davis's tools in the struggle for professionalism were quality, organization, communication, and accountability—tools that still are potent today.

*Doctor-owned and operated medical schools.* Medicine in early America was left primarily to family members or lay healers. By the 19th century, doctor-owned medical schools grew like weeds in an untended garden. These doctor-owned schools depended on tuition, so competition for students was keen and quality of education uneven. By 1850, there were 42 medical schools in the United States while there were 3 medical schools in all of France.

Most medical schools required no more than a high

school degree to enter. They lacked laboratories, leaving lectures by practicing doctors as the only form of instruction. Students learned the art of medicine through four-year apprenticeships with local physicians.

Most licensing laws, if they were enforced, recognized any medical school diploma as a substitute for a license. And, in many states, applicants for medical licenses did not even need a medical degree, so long as they completed their apprenticeships.

In this environment, a medical school that raised its educational standards or lengthened its two-year course of study risked losing students and tuition income to less demanding schools.<sup>2</sup> Though very much a product of this system, Davis was committed to changing it.

Davis was the youngest of seven children from a farming family in Greene, New York. He attended neighborhood schools, taking some science courses at Cazenovia Seminary, 15 miles north of Syracuse, New York. He went on to study medicine in 1834 at the College of Physicians and Surgeons in Fairfield, New York. Davis served his appren-



ticeship under two local doctors, paying one of them tuition by tending his cows.

After graduation, Davis practiced in Vienna, New York, where he married 17-year-old Anna Maria Parker. The couple later moved to Binghamton, New York, where Davis established a practice in medicine, surgery, and midwifery.

Davis continued his own private studies, publishing articles in medical journals and engaging in local debating societies. He joined the Broome County Medical Society and later became its delegate to the New York State Medical Society, where he honed his organizational skills.

Davis was committed to raising the standards of medical education and creating an independent licensing system for physicians. Those two reforms alone would have a profound effect on restricting the number of entrants into the field of medicine.

Davis first proposed raising academic standards at the New York State Medical Society, but the idea was rejected. Though Medical Society members recognized the benefits to the profession, the New York schools feared they would lose students to schools in other states. Davis and like-minded reformers were caught in a battle that pit the interests of the profession against the individual interests of doctors who

depended on schools for their livelihoods.<sup>2</sup>

The state of medical education in the United States in the 19th century was summed up by Harvard's reform President Charles Eliot: "The ignorance and general incompetency of the average graduate of American medical schools at



© American Medical Association 1996.

*Nathan Davis, MD, circa 1850.*

the time when he receives the degree which turns him loose upon the community, is something horrible to contemplate. The whole system of medical education in this country needs thorough reformation."<sup>2</sup>

Davis and the reformers believed that raising educational standards had to transcend state boundaries. This had to

be a national issue. Davis proposed organizing a national convention to consider ways of raising the standards of medical education; the convention was held in New York in 1846. Davis's list of reforms included four items:

"First. That it is expedient for the medical profession of the United States to institute a National Medical Association.

"Secondly. That it is desirable that a uniform and elevated standard of requirement for the degree of MD should be adopted by all medical schools in the United States.

"Thirdly. That it is desirable that young men, before being received as students of medicine, should have acquired a suitable preliminary education.

"Fourthly. That it is expedient that the medical profession in the United States be governed by the same code of medical ethics."<sup>3</sup>

The American Medical Association (AMA) was founded a year after the convention, but it would take 50 years for many of Davis's reforms to gain acceptance.

Davis left New York in 1849 to become a professor of physiology and general pathology at Rush Medical College, in Chicago. At Rush, Davis proposed reforms in preliminary educational requirements, but he resigned when his reforms were rejected by the school's dean.

Davis helped found the Medical Department of Lind University, which later became Chicago Medical College, the predecessor of Northwestern University Medical School. Chicago Medical College was a pioneer because it imposed entrance examinations and had a graded course of study.

After the Civil War, attention started to focus on improving domestic medical education. Many of the world's medical innovations were coming from Europe, while American schools were considered intellectual backwaters producing little original research. American doctors were basically tradesmen, competing for patients against homeopaths and chiropractors. Meanwhile, patent medicine-makers preached the virtue of self-medication with their questionable and unregulated products. Advertisements for these products undermined medicine, scorning doctors for their prolonged and expensive treatments.

It took educational reform at Harvard Medical School and the creation of the educational paradigm of Johns Hopkins Medical School to spur other

schools to raise their standards. Harvard and Hopkins were innovators in that they lengthened medical training from two years to three or four years and required laboratory work rather than lectures.

Johns Hopkins was a bold experiment in medical school education. Started by a \$7 million endowment from Baltimore merchant Johns Hopkins, it was the first school to take medical

ry science, followed by two years of hospital work under the direction of the faculty.

Once the tide of educational reform had risen, the other schools had to act. A number of schools started raising their standards.

The more advanced schools formed a national organization in 1890 that established a standard of three years of training, with required work in histology,

chemistry, and pathology. The organization—the Association of American Medical Colleges—represented a little more than one-third of the nation's medical schools. By 1893—the year Johns Hopkins opened—more than 96 percent of the

nation's medical schools required three or more years of work.<sup>2</sup> Faced with higher costs of providing libraries and laboratories, and declining enrollments, many of the marginal medical colleges folded.

*The oversight of licensing.* Davis was an ardent supporter of independent licensing. With one licensing body, there would be a single entry point into the profession and a way to limit the numbers of practitioners. Separate state boards



AMA President Dr. Johnson honored Dr. Ziskin with the Nathan Davis Award.

education out of the hands of local practitioners and into the hands of full-time teachers dedicated to teaching and research.<sup>2</sup> It was the first school to require a college degree for admission.

Johns Hopkins also was the first school to marry medical school education with hands-on hospital training so that students could apply their knowledge. During the first two years at Johns Hopkins, a medical school student studied laborato-



*Davis envisioned that state medical societies would have a voice in setting licensing standards because they would be the ones to appoint the state boards of medical examiners.*

issuing licenses would ensure professional objectivity and raise the level of professionalism.

Davis envisioned that state medical societies would have a voice in setting licensing standards because they would appoint the state board of medical examiners.

The first state board of medical licensing was established under medical society control during the 1870s in Texas. By 1898, all states had medical licensing boards.

Davis continued to pursue his interest in building medical organizations. He organized the Chicago Medical Society and the Illinois State Medical Society. A prolific writer and medical historian, Davis edited the *Chicago Medical Journal*, the *Chicago Medical Examiner*, and the *Northwestern Medical and Surgical Journal*. Davis headed the movement to bring clean water and an efficient sewage system to the city. In 1850, he founded Mercy Hospital, the city's first hospital.

*AMA in trouble.* In its third decade of life, the AMA and its annual journal were floundering, weakened by internal squabbling and cash problems. The AMA's journal, *Transactions*, originally a yearly newsletter to relate the transactions of the AMA's annual meetings,

was dismissed for lack of relevance because of its long publication delays.

*Transactions* had no influence among the nation's doctors. Without radical changes in the AMA and its publication, there was little chance the AMA would grow. A weekly journal was seen as salvation. A timely journal publishing scientific articles and news of the AMA's accomplishments might be the remedy to boost interest—and membership—in the AMA.<sup>4</sup>

Davis was chosen as president of the journal's Board of Trustees in 1883. After significant market research, Davis ascertained readership interest in a national medical journal. The first issue of the new *Journal of the American Medical Association (JAMA)* appeared July 14, 1883, with Davis as its editor.

In the five and one-half years Davis served the post, JAMA's subscriptions grew. Circulation rose from 3,800 in its first year to 5,000 four years later. At last, Davis had a national forum for American scientific research. Just as important, JAMA had its own source of income. By 1898, its circulation reached 11,270. Financed with AMA membership dues and advertising, JAMA's income rose fivefold to

\$25,000, giving it enough money to purchase its own offices and printing facilities.<sup>5</sup>

Davis continued lecturing and practicing medicine until two weeks before his death in 1904 at the age of 87. The magazine, plus changes in the AMA's internal organization, boosted interest and the influence of the organization. Today, some 40 percent of practicing doctors belong to the AMA. JAMA's English language circulation is 330,000 and its editions are distributed internationally. It would be hard to find an American doctor today who has never read a copy of JAMA.

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*Pauline M. Seitz*

## HOMEGROWN PROGRAM PROMOTES HEALTH IN NEW JERSEY

*The emphasis for New Jersey Health Initiatives is to improve health and health care for the people throughout the state, many of whom lack access to these services.*

**Ms. Seitz is director,  
New Jersey Health  
Initiatives, in Princeton.**

Since its inception a decade ago, New Jersey Health Initiatives (NJHI) has awarded nearly \$13 million to 50 projects across the state. The Robert Wood Johnson Foundation program has awarded 24 recent grants (Table) and, in July, awarded \$1 million more to 6 new Garden State grantees. Based in Princeton, NJHI is administered through the Health Research and Educational Trust (HRET), which is part of the New Jersey Hospital Association.

While supporting the Foundation's overall objectives—assuring access to basic health services, reducing harm from substance abuse, and improving the way services are organized and provided to people with chronic health conditions such as AIDS and Alzheimer's—NJHI links the Foundation to the health needs of people in its home state.

Grantees include government agencies such as the New Jersey state Department of Health and Senior Services (DHSS) (a model for single-entry for long-term care), major hospitals such as the University of Medicine and Dentistry of New Jersey (substance abuse screening and elderly mental health projects), and grassroots groups such as the Morris County Organization for Hispanic Affairs (preventive care/health education for 15,000 disadvantaged community residents), and the Northern New Jersey Maternal Health Consortium (layworkers—doulas—providing support for pregnant women with substance abuse problems). Grant amounts range from \$50,000 to a maximum of \$250,000.

Whether the grantees are large or small entities, the emphasis is the same: improving health and health care for the people throughout the state, many of whom lack access to

these services due to age, ethnicity, language, or location. Additionally, NJHI gives grantees the tools to grow and sustain projects through extensive technical assistance in building organizational, business, and fundraising skills and forming funding partnerships with local sources of support.

Many of these projects, either individually or through replication, have broad policy impact, as the following three profiles show.

**Hyacinth AIDS Foundation—New Brunswick.**

*Education, Training, and Volunteer Resources Project.*

People living with HIV/AIDS in New Jersey are not alone. There is a network of trained volunteers to offer support through the Hyacinth AIDS Foundation. This three-year project (October 1995 to September 1998) is a model for volunteers' delivery of support services and health information to



**Table. Some New Jersey Health Initiatives grantees.**

<b><u>Grantee</u></b>	<b><u>Grant Award</u></b>
<ul style="list-style-type: none"><li>Alzheimer's Association, Northern NJ Chapter, Parsippany <i>Grant Period: 7/96-6/98</i></li></ul>	\$217,202
<ul style="list-style-type: none"><li>Cadbury Continuing Care Retirement Community, Cherry Hill <i>Grant Period: 12/93-11/96</i></li></ul>	\$165,930
<ul style="list-style-type: none"><li>Community Health Care, Inc., Bridgeton <i>Grant Period: 10/95-9/98</i></li></ul>	\$225,147
<ul style="list-style-type: none"><li>The Cooper Health System, Camden <i>Grant Period: 7/96-6/99</i></li></ul>	\$249,996
<ul style="list-style-type: none"><li>Enable, Inc., Princeton <i>Grant Period: 7/96-6/99</i></li></ul>	\$150,032
<ul style="list-style-type: none"><li>Freedom Foundation of New Jersey, West Orange <i>Grant Period: 6/93-5/96</i></li></ul>	\$177,220
<ul style="list-style-type: none"><li>Hispanic Family Center of Southern New Jersey, Inc., Camden <i>Grant Period: 12/94-11/97</i></li></ul>	\$238,939
<ul style="list-style-type: none"><li>Hyacinth AIDS Foundation, New Brunswick <i>Grant Period: 10/95-9/98</i></li></ul>	\$232,792
<ul style="list-style-type: none"><li>Jersey City Day Care 100, Inc., Jersey City <i>Grant Period: 10/96-9/99</i></li></ul>	\$225,000
<ul style="list-style-type: none"><li>Jersey City Medical Center, Jersey City <i>Grant Period: 6/94-8/96</i></li></ul>	\$250,000
<ul style="list-style-type: none"><li>Jesuit Urban Service Team, Camden <i>Grant Period: 7/96-6/99</i></li></ul>	\$80,604
<ul style="list-style-type: none"><li>Kresfield Adult Social Daycare Center, Inc., Washington <i>Grant Period: 6/94-8/96</i></li></ul>	\$188,335

<b><u>Grantee</u></b>	<b><u>Grant Award</u></b>
<ul style="list-style-type: none"> <li>• Martin House Community for Justice Foundation, Trenton <i>Grant Period: 10/92-4/97</i></li> </ul>	\$250,000
<ul style="list-style-type: none"> <li>• Matheny School and Hospital, Peapack <i>Grant Period: 7/96-6/97</i></li> </ul>	\$50,000
<ul style="list-style-type: none"> <li>• Morris County Organization for Hispanic Affairs, Dover <i>Grant Period: 10/95-10/98</i></li> </ul>	\$240,583
<ul style="list-style-type: none"> <li>• New Jersey Association of Corrections, Trenton <i>Grant Period: 6/93-10/96</i></li> </ul>	\$229,056
<ul style="list-style-type: none"> <li>• New Jersey State Department of Health and Senior Services, Trenton <i>Grant Period: 1/95-12/97</i></li> </ul>	\$238,251
<ul style="list-style-type: none"> <li>• New Jersey Health Care Facilities Financing Authority <i>Grant Period: 6/92-6/96</i></li> </ul>	\$111,462
<ul style="list-style-type: none"> <li>• Northern New Jersey Maternal Health Consortium, Paramus <i>Grant Period: 1/95-6/96</i></li> </ul>	\$238,939
<ul style="list-style-type: none"> <li>• Prevent Child Abuse-New Jersey Chapter, Inc., Newark <i>Grant Period: 10/95-9/98</i></li> </ul>	\$249,086
<ul style="list-style-type: none"> <li>• Princeton Center for Leadership Training, Princeton <i>Grant Period: 9/94-8/96</i></li> </ul>	\$248,919
<ul style="list-style-type: none"> <li>• Samaritan Hospice, Moorestown <i>Grant Period: 7/96-6/99</i></li> </ul>	\$230,078
<ul style="list-style-type: none"> <li>• UMDNJ Community Mental Health Center/Addictions Screening Project, Piscataway <i>Grant Period: 12/93-11/96</i></li> </ul>	\$237,881
<ul style="list-style-type: none"> <li>• UMDNJ Community Mental Health Center/Elderly Mental Health Project, Piscataway <i>Grant Period: 12/94-11/96</i></li> </ul>	\$232,619



*NJHI grantees include government agencies, major New Jersey hospitals, and grassroots groups. Grant amounts range from \$50,000 to a maximum of \$250,000.*

people with HIV/AIDS in a wide geographic area and links clients and caregivers as "partners in care" through public health/AIDS education programs.

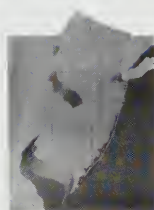
According to Paula Toynton, Hyacinth's director of education and volunteer resources, the project has exceeded its goal of maintaining at least 300 active volunteers per year. Currently, there are 587 active volunteers involved in the project.

The organization trained 99 volunteers in the first six months of the grant period (October 1995 to May 1996) and conducted its first volunteer training session in Spanish in Jersey City.

In June, Hyacinth started "Caregivers and Treatment Education," a series of workshops on health care and HIV-related issues in New Brunswick and in the Newark/Jersey City area.

Satisfying a key NJHI program goal—to encourage community organizations to seek and secure local, ongoing sources of support—the HIV

educators component of the volunteer program received funding from AT&T for a project called "Partners in Prevention" workplace education effort. AT&T employees are trained as HIV educators who offer training to peers in businesses throughout New Jersey.



### New Jersey Health Initiatives

Hyacinth also received a grant from DHSS called, "Project POW!" (Prevention Outreach Works), targeting women, young people, and homosexuals.

According to Toynton, Hyacinth plans to offer the workplace education programs to regional chambers of commerce. This has the potential for a dual benefit: identifying new people in need of Hyacinth's

services and promoting the long-term sustainability of the organization's HIV/AIDS education efforts.

### **Community Health Care, Inc.—Bridgeton.**

#### *Farmworker Lay Health Promotion Project.*

You might not think that the health of migrant workers is a problem native to New Jersey, but for a group of people in the southeastern part of the state, access to care, health education, and disease prevention are growing concerns.

This three-year project (October 1995 to September 1998) is designed to provide access to health care services for seasonal and year-round farmworkers in Cumberland County, using community-based, culturally and linguistically appropriate (in Spanish for Latinos) lay health promoters.

During the peak summer growing season, there are 6,000 farmworkers in the community. In winter, 1,000 farmworkers remain, so there is a resident population in need of

*NJHI gives all of its grantees the tools to grow and to sustain projects through extensive technical assistance in building organizational, business, and fundraising skills.*

health care. Historically, most were single men from Puerto Rico. Now, there are increasing numbers of families from Mexico and Central America.

The project also provides education, followup home visits, and education to monitor farmworkers with chronic health conditions such as diabetes, high blood pressure, and HIV/AIDS. These lay health workers—12 during the peak growing season and 4 in the winter months—also provide information on healthy diets and exercise regimens. Lay health promoters attend two hours of classes two nights a week—after their “day jobs”—on topics such as program objectives, roles/responsibilities of lay health promoters, along with specific information on hypertension, diabetes, alcohol, and drug use.

In the first six months of the grant, the lay health promoters held 281 individual health education/promotion visits and 39 group education meetings with farmworkers and their families. These related to diabetes and

hypertension issues, and making dental and medical appointments.

The promoters also completed 11 community problem assessment and action planning activities in farmworker camps and homes. Staff prepared guides to identify unhealthy behaviors and developed timetables for ameliorating problems with drug/alcohol abuse, hypertension, and diabetes.

**New Jersey State Department of Health and Senior Services—Trenton.**

*NJ EASE Elderly Health Services Program.*

With NJHI funding, NJ Easy Access Single Entry (EASE) is providing a seamless set of services for the state’s 1.4 million senior citizens. NJ EASE is designed to foster the independence and dignity of older citizens, while ending the confusion and frustration they and their families often face when seeking information and help.

Although the effort has been widely publicized, its public policy “partner” is not as well known. A three-year NJHI grant to DHSS is supporting the creation of a new countywide and statewide system to improve access services for the elderly.

This grant creates a single agency within each county through which senior citizens and their families may obtain comprehensive information and referral, outreach and assistance, assessment, care planning, and care management for a broad array of social/recreational, support, and health care services.

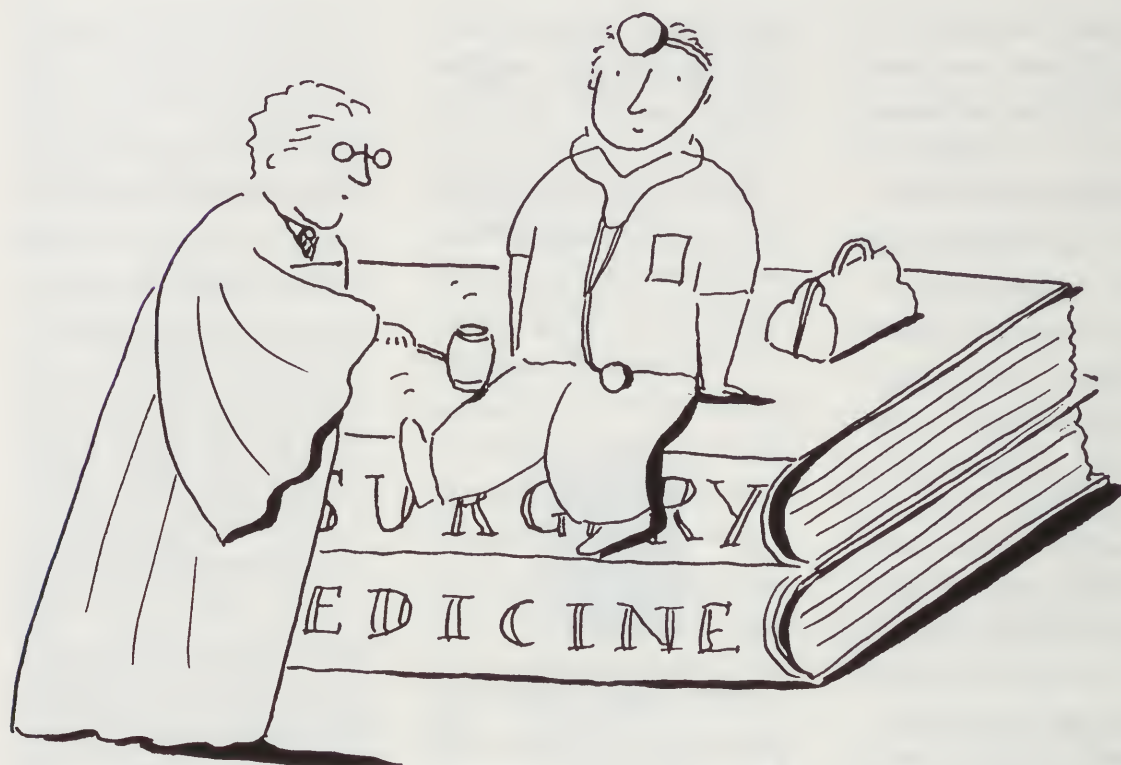
Services include educational classes and wellness programs, transportation and nutrition services, adult protective services, alternate family care, respite care, adult day care, and supportive housing programs.

On the county level, NJ EASE is being established in 4 demonstration counties. It is expected that the program will be established in all 21 counties in the state.

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*Alfred F. Tallia, MD, MPH*

## ASSESSING HEALTH CARE QUALITY USING HEDIS 3.0

**Dr. Tallia is affiliated with the Department of Family Medicine, UMDNJ-Robert Wood Johnson Medical School, New Brunswick.**

In 1980, the first of Donabedian's seminal texts on assessing and measuring the quality of health care was published.<sup>1,3</sup> Since that time, the rubric of assessing quality on the basis of an analysis of the structure, process, and outcomes of care has gained widespread acceptance in health policy and research circles. Yet, practicing physicians have remained skeptical of these and other attempts to define and measure what many still regard as an art form—the practice of medicine.

The corporatization of health care, the rise of managed care, and the historic stakeholder coalition of government and industry united in an effort to contain rising health care costs, for many years threatened to eclipse efforts to pursue a serious

exploration of quality. However, recent evidence suggests that in advanced managed care markets, new attention is being paid to quality issues by payers and patients. What role will physicians play in the pursuit of quality under managed care systems? How can physicians in New Jersey and elsewhere learn from the experience of physicians in these advanced markets? How should physicians prepare to contribute to the ongoing public discourse on quality?

The answers to these questions rest on a thorough understanding of the needs that patients and health care payers have in making judgments about the services they are receiving and purchasing. In the final analysis, the degree to which physicians align themselves with the needs of their patients will guarantee the profession a major role in the quality debate. Physicians need to become facile in the language of quality analysis,

and need to become articulate spokespersons in defense of health care quality. Excellent overviews of quality literature are provided elsewhere.<sup>4,6</sup> This article will focus on an emerging vehicle for assessing health plan quality, the Health Plan Employer Data and Information Set (HEDIS). HEDIS is a standardized set of performance measures for the managed care industry promulgated by the National Committee for Quality Assurance (NCQA).

NCQA is an independent, not-for-profit organization that assesses and reports on the quality of managed care organizations. Founded as an insurance industry organization, NCQA has evolved to include representatives from employers, labor, regulators, consumers, as well as organized medicine. NCQA has two major functions: accreditation and performance measurement/reporting. Two forms of HEDIS, HEDIS 2.5 and Medicaid HEDIS, currently are in widespread use.



*HEDIS 3.0 was developed by a broad-based, 26-member committee on performance measures, with 75 reporting set measures and 30 testing set measures.*

The types of information utilized by these versions of HEDIS are derived primarily from administrative data sets, e.g. billing reports. The quality indicators used include mainly process of care measures, many related to preventive screening. In July, in the culmination of many months of work responding to criticisms about the limitations of earlier versions of HEDIS, NCQA released for public comment the newest version, HEDIS 3.0, and recommended its adoption as an industry standard.

HEDIS 3.0 was developed by a broad-based, 26-member committee on performance measures. There are 75 reporting set measures (measures health plans will have to report in 1997), and 30 testing set measures under development. Measures fall under several broad cate-

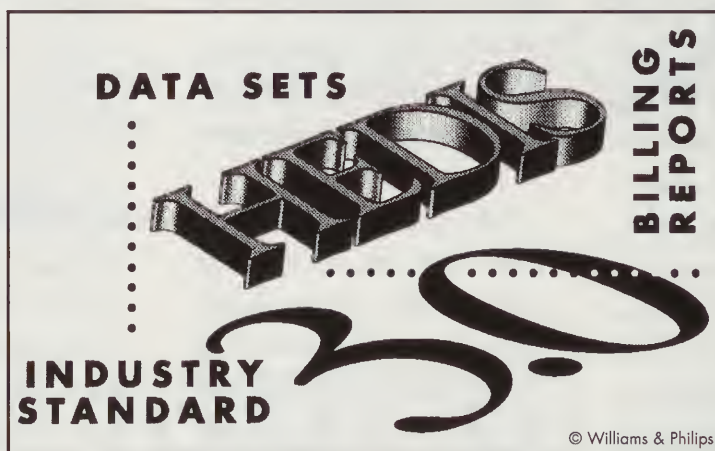
gories, including: effectiveness of care, access to/availability of care, satisfaction with care, health care plan stability, use of services, cost of care, informed health care choices, and health care plan descriptive information.

While an attempt to expand outcome measures has been made, the new ver-

This will allow better comparison among plans by these variables. The new reporting set measures also will require health plans to institute collection of information not readily obtainable through administrative data sets, meaning more data will be collected at the level of the medical record, closer to the patient-physician encounter.

Another advance in HEDIS 3.0 is the merging of public and private reporting requirements. New version measures will treat all patients as the same, regardless of insurance, e.g. Medicaid, Medi-

care, commercial. This will allow better comparison among different patient populations by a host of other socioeconomic variables that affect health status. HEDIS 3.0, therefore, does represent progress in collecting information of use to physicians and



sion continues to rely heavily on process measures. Given long lead times to achieve many outcomes, this is not necessarily bad. However, what is new and significant is the addition of consumer satisfaction and patient reported functional status measures.

*Implementing HEDIS 3.0 will be a challenge for insurance companies and could present opportunities for the physicians with whom they contract.*



patients for the purpose of assessing and comparing certain measures of the quality of care rendered under managed care plans.

Implementing HEDIS 3.0 will be a challenge for insurance companies and could present opportunities for the physicians with whom they contract. The reporting set and testing set measures should be viewed as measures in evolution, and represent a chance for communication among NCQA, man-

aged care entities, patients, and providers. Further information on HEDIS 3.0 and NCQA can be obtained by visiting the NCQA Internet web site at <http://www.ncqa.org>. Physicians must become involved in developing and piloting new measures to assess the quality of care. Only as active participants and leaders in quality assessment will we have the opportunity to mold the quality debate and address future challenges in the health care system.

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**NJM**



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Contact Robert J. Rahl, CPA

## ARE WE PROMOTING TOO MANY ALLIED HEALTH PROFESSIONALS INSTEAD OF PHYSICIANS?

David M. Gibson, EdD

William E. Ryan, MD

*The issue of “too many” is far less important than what kinds of health professionals we will need in the future.*

This question begs its antecedent question, namely what kinds of health professionals should we be educating? According to most sources, there are nearly 200 health care worker groups who fall under the rubric of allied health professionals. Some are very

few in number such as cytotechnologists; some are in great supply such as entry-level radiographers. The real issues for the allied health workforce are fourfold: the supply/demand ratio for selected allied health professions; the predominant locus of practice; the realistic mix of multi-skilled workers that can exist without loss of the primary skills necessary for safe practice; and how to provide more interdisciplinary education to enhance our students' knowledge and appreciation of the broad psychosocial, moral, and ethical implications inherent in the receipt and delivery of health care. Related to these issues is the determination of what truly constitutes a core curriculum for all health professionals.

Notwithstanding the nearly full immersion of managed care in selected parts of the United States, the Bureau of Labor Statistics still projects serious

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*We should promote the health care professional who best meets and addresses the needs of the patient.*

The answer to this difficult question is most complicated. Obviously, we should aim for an appropriate proportional promotion of health care professionals and seek this accomplishment.

The underlying question we need to answer is, “Who is the more adequate practitioner to address a given clinical

situation and need?” I think we should then promote the health care professional who best meets and addresses the needs of the patient. In this fast-changing world of health care reform and managed care promotion, adequate data are very hard to obtain. The needs of the populace, which in former years, were relatively static, now are undergoing radical revision with the changing health care environment and the introduction of managed care plans.

It is true that highly skilled personnel, such as physicians, do not need to perform tasks that more easily and less expensively can be performed by personnel who are trained specifically for these tasks. For decades now, this has been the modus operandi of most hospitals and physician practices. X-ray technicians, laboratory technicians, physical therapists, and a host of trained health care professionals always have assisted in patient care, which has been orchestrated by the physician.

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## Gibson

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shortages of well-trained allied health professionals such as physician assistants, medical laboratory personnel, physical therapists, dietitians, midwives, and technical support personnel such as therapists, technologists, and aides. So, too, does the New Jersey Department of Labor in its 1996 publication, *Occupational Outlook*. Until 15 years ago, the predominant locus of practice for the allied health workforce was in hospitals. Today, over 60 percent of this workforce practices in alternate settings, such as ambulatory and community-based health care settings or in home health care. While there seems to be little doubt among allied health educators that the numbers and mix of allied health professionals will have to change, there seems to be little correlation with the number of physicians that should be graduated. Rather, the relationship is more closely tied to the types of specialties that physicians pursue. Certainly, many of the medical specialties drive the need for certain types of allied health personnel, for example, radiology for the imaging technologists or vascular surgery for vascular technologists. As the delivery of health care changes both in focus and locus, the challenge to all health professions' educators is to create new venues of clinical practice and revised curricula to best prepare our graduates to work in teams. In this regard, allied health educators throughout the nation are seeking ways in which to expand the skills of their students and their graduates to enhance their services and maintain their marketability. For instance, schools of allied health are responding to the challenges of change by initiating interdisciplinary studies, integrating core courses across disciplines, such as basic nutrition and patient care relationships and techniques.

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## Ryan

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But the playing field now has changed. Physicians no longer are seeing every emergency room patient. Whole clinics are being run by nurse practitioners. Laboratory blood drawing and EKGs no longer are being performed in some hospital settings by technicians with the training of ten years ago. Yet, physicians are being asked to oversee the assessment and treatment process; and they have increased concerns about liability and quality of care.

I decry the headlong rush in the downgrading of patient care and the inappropriate assignment of people to services who have considerably less expertise in patient management. It is true that many allied health professionals are well trained and have considerable experience and knowledge. In a situation, which is appropriate, they may address patient needs in a more cost-effective manner. However, this should not be done at the expense of excellent patient care. Allied personnel should not be placed in the position of rendering care beyond their training and expertise.

This question is very difficult because the health care industry is having a particularly difficult time assessing its needs. Hospitals are buying practices and merging. Enrollees are being assigned and re-assigned into plans. Trying to get a snapshot of personnel needs is an almost impossible job. Therefore, to assess the number of physicians, physician assistants, nurse practitioners, optometrists, physical therapists, and other allied health professionals that we need is very difficult.

We also must be very cognizant of the fact that allied health professionals are lobbying and promoting themselves as "same treatment, less expensive" practitioners. They are convincing the Legislature and other politicians that they can provide the same service with a substantial reduction in cost. This was one of the great arguing points when the optometrists approached the Legislature for prescription writing privileges.

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## Gibson

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It seems neither realistic nor cost effective that physicians would assume the responsibilities of technicians, no matter how tight the market becomes for health care providers. Patently, payers would be very wary of reimbursing physicians for technical services that currently are performed by lesser educated and lesser paid personnel. Also, it would hardly be cost effective for physicians to assume these responsibilities, particularly under any capitated managed care program. Moreover, the rigors of the medical curriculum and the cost of medical education are simply disproportionate to the provision of these services. As is the case with allied health and nursing educators, physician educators are increasingly attempting to wrestle with the changing forces within health care as they seek ways to include more emphasis in the curriculum on preventive care, patient counseling, including the psychosocial and information technology of modern health care. These are new sets of skills that physicians will need as primary care "gatekeepers" to assure appropriate quality, access, and cost containment in medical practice. These ends can be met well through the thoughtful utilization of allied health professionals.

The issue of "too many" is far less important than what kinds of physicians, nurses, and allied health professionals will we need at the dawn of the 21st century. The marketplace will clearly determine numbers. Together, however, our health professions schools, keyed to health care changes, have the opportunity to develop the right mix of health professionals.

*Dr. Gibson is dean, School of Health Related Professions, UMDNJ.*



## Ryan

*continued from page 58*

Currently, there are a number of bills in the Legislature that erode, if you will, the previous domain of physicians. For example, bill A-1654 by Assemblymen Corodemus and Cohen "permits licensed psychologists to perform competency evaluation in criminal cases." This may or may not displace trained psychiatrists. A-2130 by Assemblywomen Wright and Vandervalk allows home health care agencies "to possess and administer noncontrolled prescription drugs." A-1418 by Assemblymen Garrett and Augustine provides "that licensed audiologists and speech language pathologists are eligible for reimbursement under certain health insurance policies." S-890 by Senator Sinagra "provides for use of certain health care facilities and appropriate privileges for licensed optometrists."

It has been noted that physical therapists in New Jersey wish to have the privilege of pelvic examinations. In New York State, during the summer, chiropractors were able to achieve dramatic success when they pushed through the Legislature a bill that would "require health plans to provide unlimited chiropractic services." The bill was passed through both houses but Governor Pataki vetoed it.

These bills give indications that allied health professionals are promoting themselves and doing a good job of it at the expense of physician services.

We need a commission or other objective means of assessing the health manpower needs of the state such as the suggestions for Medicare revision.

I firmly believe that the new health care plans, with an emphasis on care being directed by non-physicians, will require the presence of more allied health professionals at the expense of physicians. I do not welcome this trend and I think that we should be wary of such a process.

*Dr. Ryan is a past-president of MSNJ and a member of its Council on Legislation.*





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# COMMENTARY

## The “new” Board of Medical Examiners

Created over 100 years ago, the New Jersey state Board of Medical Examiners (BME) is charged with the responsibility of ensuring that New Jersey's physicians are trained, competent, and ready, willing, and able to treat New Jersey's citizens with skill and safety. BME is the largest standing board of its kind in the nation, with 21 members appointed by the governor to 3-year terms.

BME's mission is threefold: set education, training, and examination standards for new licensees through its credentialing process; investigate complaints and regulate physician conduct through its disciplinary function; and develop and set standards for the practice of medicine through its regulatory process.

The 1990s brought about dramatic changes in the health care industry. These changes have imposed new demands on medical boards requiring them to adapt and respond to new challenges. New Jersey is facing a number of major issues. In order to be responsive, the leadership of BME has tackled thorny regulatory issues by seeking advice, input, and consensus from the regulated community. There also is a heightened awareness by BME of the demands of modern medical practice.

The prominent issue before the public and the health care community has been the managed care revolution. In response to concerns that contractual provisions and reimbursement of managed care contracts potentially interfere with the physician-patient relationship, BME conducted three public hearings to solicit the views of the public and the medical community. In its July 1996 report, BME determined that financial provisions in managed care contracts that provide incentives to limit treatment or referrals are contrary to the best interests of patient care. BME vowed to aggressively pursue investigation and discipline of such cases, noting that

*Kevin B. Earle*

**NJM**



licensees are obligated to provide an appropriate standard of care regardless of the reimbursement arrangement. BME further determined that physicians are obligated to explore all possible treatment options with their patients, including those limited or not covered by a managed care plan.

New regulations and guidelines on sexual misconduct were developed that clarify the boundaries of professional relationships and caution physicians to "avoid verbal or physical behavior that might be interpreted as inviting a romantic or sexual relationship." New Jersey is one of the first states in the country to deal with this issue in a comprehensive manner.

New and stronger relationships have been forged with MSNJ's Physicians' Health Program through BME's Alternative Resolution Program. The new program provides stronger monitoring and supervision of the treatment of physicians who are impaired because of alcohol or substance abuse, debilitating diseases, or the aging process, while maintaining confidentiality of those physicians who are compliant in their treatment. BME may impose disciplinary sanction when a physician's continued practice potentially threatens patient health or safety.

Several new regulatory initiatives, developed with significant input from various task forces, soon will be implemented. An increase in reported incidents and disciplinary actions involving the administration of anesthesia and performance of surgeries in an office setting resulted in the develop-

ment of comprehensive standards embodied in new regulations. In addition, the changing face of business practices has resulted in substantive proposed regulatory changes governing the corporate practice of medicine. The new regulations represent BME's attempt at simplifying and

clarifying its position on acceptable business practices and formats.

Finally, increasing demands that government be responsive to the public and its licensees have resulted in a number of new efforts to increase customer satisfaction when dealing with the office. The Department of Law and Public Safety is supporting efforts to expedite BME's credentialing process. In addition, the development of new automated information systems for the Division of Consumer Affairs will result in more efficient processing of a number of services from renewals to verifications. *Mr. Earle is the executive director, BME.*

## COMMENTARY



Kevin B. Earle

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### DECEMBER 1996

DECEMBER 4th

#### **Genetic Models of Hypertension**

*Richard P. Lifton, M.D., Ph.D.*

Associate Professor of Medicine, Nephrology, and Genetics

Yale University School of Medicine, Assistant Investigator, Howard Hughes Medical Institute  
New Haven, CT

DECEMBER 11th

#### **Cardiac Auscultation for the Generalist and Office Practice**

*Bernard L. Segal, M.D.*

Clinical Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, MCP Division  
Philadelphia, PA

*Gerald Scharf, D.O.*

Clinical Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

*Dean G. Karalis, M.D.*

Clinical Assistant Professor of Medicine

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

*Farooq Chaudhry, M.D.*

Professor of Medicine

Division of Cardiovascular Diseases, Director  
Cardiac Echo Labs, Allegheny University Hospitals  
Hahnemann Division, Philadelphia, PA

*John J. Ross, Jr., RCPT, RDCS*

Research Assistant Professor

Division of Cardiovascular Diseases, Allegheny University Hospitals, Hahnemann Division  
Philadelphia, PA

### DECEMBER 1996

DECEMBER 18th

#### **Advances in the Use of Interferon**

*Moshe Talpaz, M.D.*

Professor of Medicine

University of Texas School of Medicine, Interim Chairman, Department of Bioimmunotherapy  
M.D. Anderson Cancer Center, Houston, TX

DECEMBER 25th

No Grand Rounds

### JANUARY 1997

JANUARY 1st

No Grand Rounds

JANUARY 8th

#### **Domestic/Spousal Abuse**

*Sarah Buel, J.D.*

Adjunct Professor

Harvard School of Medicine and University of Texas School of Law, Special Counsel, Texas District and County Attorneys Association  
Austin, TX

JANUARY 15th

#### **Telemedicine—The Future of Medical Education and Practice**

*Jay H. Sanders, M.D.*

Senior Scientist

Georgia Institute of Technology, McLean, VA

JANUARY 22nd

#### **Reversing Endothelial Dysfunction with ACE Inhibitors**

*D.B. John Mancini, M.D.*

Professor and Head, Department of Medicine  
University of British Columbia, Vancouver Hospital and Health Sciences Center, Vancouver, British Columbia, Canada

JANUARY 29th

#### **Indications and Findings of Lower GI Endoscopy**

*Jerome Waye, M.D.*

### JANUARY 1997

Clinical Professor of Medicine

Mt. Sinai School of Medicine, Chief, GI Endoscopy Units, Mt. Sinai Medical Center and Lenox Hill Hospital, New York, NY

### FEBRUARY 1997

FEBRUARY 6th

#### **Early Arthritis: Clues to Pathogenesis of**

#### **Rheumatoid Arthritis**

*Ralph Schumacher, M.D.*

Professor of Medicine

University of Pennsylvania School of Medicine, Director, Arthritis Center, VA Medical Center, Philadelphia, PA

FEBRUARY 12th

#### **Cystic Fibrosis: Advances in Gene Therapy**

*Michael Knowles, M.D.*

Professor of Medicine

University of North Carolina School of Medicine, Director, Adult Cystic Fibrosis Clinic, Division of Pulmonary Medicine, University of North Carolina at Chapel Hill, Chapel Hill, NC

FEBRUARY 19th

#### **Antithrombosis Therapy in Acute Myocardial Infarction**

*Robert Califf, M.D.*

Professor of Medicine

Duke University School of Medicine, Director, Duke Clinical Research Institute, Vice Chancellor for Clinical Affairs, Duke University Medical Center, Durham, NC

FEBRUARY 26th

#### **The Future of ACE Inhibitors in Cardiovascular, Renal Disease and Hypertension**

*Leon Ferder, M.D.*

Professor of Medicine

Rector, Universidad Hebraica Argentina  
Buenos Aires, Argentina

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DECEMBER 11, 1996

#### **Cardiac Auscultation for Office Practice**

Course Co-Directors: Bernard L. Segal, M.D., Allan B. Schwartz, M.D., Farooq Chaudhry, M.D., Dean Karalis, M.D., Gerald Scharf, D.O., John J. Ross, Jr., RCPT, RDCS

JANUARY 21-22, 1997

#### **Advances in Diagnosis and Management of Cardiovascular Disease**

Course Co-Directors: Marc Cohen, M.D., Susan Brozena, M.D.  
Seminar Director: Allan B. Schwartz, M.D.

FEBRUARY 18-19, 1997

#### **Prevention and Treatment of Abnormalities of Thrombosis in Cardiovascular Disease**

Course Director: Marc Cohen, M.D.  
Seminar Director: Allan B. Schwartz, M.D.

**Seminar Director:** Allan B. Schwartz, M.D., Professor of Medicine, Chief of Service, Director of Continuing Medical Education for the Department of Medicine

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# calendar

## WINTER 1996-1997

### **Alternative Medicine**

December 10, 1996  
Jersey Shore Medical Center, Neptune  
908/776-4420

### **Telemedicine**

December 11, 1996  
Health Sciences Library Assoc.  
201/996-2326

### **Radiology Meeting**

December 19, 1996  
Location to be announced  
609/275-1911

### **Management of Asymptomatic**

#### **HIV Infection**

January 8, 1997  
Rahway Hospital  
908/381-4200

#### **Aspects of HIV/AIDS**

January 8, 1997  
Veterans Medical Center, Lyons  
908/647-0180

### **Management of Asymptomatic**

#### **HIV Infection**

January 9, 1997  
Newcomb Medical Center, Vineland  
609/691-9000

### **Evoked Potentials and Magnetic Stimulation**

January 10-11, 1997  
Kessler Conference Center, West Orange  
201/731-3600

### **Macular Degeneration**

January 11, 1997  
Scheie Eye Institute  
215/662-8100

### **Dermatology Meeting**

January 14, 1997  
Location to be announced  
609/275-1911

### **Domestic Violence Issues**

January 15, 1997  
Union Hospital  
908/687-1900

### **AIDS**

January 15, 1997  
Medplex Rehabilitation Hospital  
609/988-8778

### **Radiology Meeting**

January 16, 1997  
Location to be announced  
609/275-1911

### **Handling**

#### **Violent Patients**

January 16, 1997  
Woodbridge Developmental Center  
908/499-5500

### **Nephrology**

#### **Monthly Meeting**

January 21, 1997  
Overlook Hospital, Summit  
908/522-2000

### **Anesthesiology**

#### **Meeting**

January 21, 1997  
Forsgate Country Club  
908/521-0070

### **Ultrasound**

#### **Meeting**

January 23, 1997  
JFK Conference Center, Edison  
908/632-1615

### **Visiting Professor Lecture**

January 23, 1997  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **Glaucoma 1997**

February 1, 1997  
Scheie Eye Institute  
215/662-8141

### **Postprandial Hyperglycemia**

February 4, 1997  
West Hudson Hospital, Kearny  
201/955-7000

### **Domestic Violence Issues**

February 5, 1997  
Rahway Hospital, Rahway  
908/381-4200

### **Anticoagulation Therapy**

February 5, 1997  
Union Hospital  
908/687-1900

### **Anticoagulation**

#### **Therapy**

February 5, 1997  
Veterans Medical Center, Lyons  
908/647-0180

### **Albert Siegel**

#### **Symposium**

February 5, 1997  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **Head and Neck Oncology**

#### **Meeting**

February 6, 1997  
Location to be announced  
609/275-1911

### **Dermatology**

#### **Meeting**

February 11, 1997  
Location to be announced  
609/275-1911

### **Radiology Meeting**

February 20, 1997  
Location to be announced  
609/275-1911

### **Ophthalmic Plastic Surgery**

February 22, 1997  
Scheie Eye Institute  
215/662-8141

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- ⇒ **How do New Jersey residents feel about their doctors?**  
A poll by the Eagleton Institute of Rutgers University highlights patient satisfaction with physicians and health care.
- ⇒ **How have the new cardiac catheterization regulations changed the delivery of this procedure?**  
Writer Bill Berlin explores the pros and cons of the new regulations and how they affect hospital delivery of services.
- ⇒ **Who should provide subacute care in New Jersey?**  
In a point counterpoint format, Rick Abrams, vice-president of the New Jersey Association of Health Care Facilities, and Gary Carter, president of the New Jersey Hospital Association, debate the issue of subacute care.
- ⇒ **What does the state offer for assisted living and alternative family care options?**  
John A. Calabria, program manager for the Department of Health and Senior Services, Division of Health Facilities Evaluation and Licensing, discusses the choices available for long-term care.
- ⇒ **What's happened this year in the state Legislature?**  
MSNJ lobbyist Clark Martin reviews the year's legislative actions.
- ⇒ **Tune in for Mailstop, F.Y.I., Newsmakers, Editor's Desk, and Calendar.**



# calendar

## WINTER-SPRING 1997

### **Peripheral Vascular Disease: Non-Invasive Diagnosis**

February 27, 1997  
Woodbridge Developmental Center  
908/499-5500

### **Visiting Professor Lecture**

February 27, 1997  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **Upper Extremity Prosthetics and Orthotics**

February 28-March 1, 1997  
Kessler Conference Center, West Orange  
201/731-3600

### **Domestic Violence Issues**

March 5, 1997  
Veterans Medical Center, Lyons  
908/647-0180

### **Infection Control in the HIV Era**

March 5, 1997  
Rahway Hospital  
908/381-4200

### **Neurophysiology**

March 5-8, 1997  
Thomas Jefferson Medical College  
215/955-6992

### **Management of Pediatric HIV**

March 6, 1997  
St. Peter's Medical Center  
908/745-8600

### **Physical Medicine and Rehabilitation**

March 7-16, 1997  
Headquarters Plaza, Morristown  
609/275-1911

### **Cornea and External Disease**

March 8, 1997  
Scheie Eye Institute  
215/662-8141

### **Meeting on Anticoagulation Therapy**

March 11, 1997  
Our Lady of Lourdes, Camden  
609/757-3500

### **Oncology Clinical Meeting**

March 12, 1997  
The Manor, West Orange  
201/325-2060

### **Identification and Management of HIV Infection**

March 12, 1997  
Mediplus Rehabilitation Center  
609/988-8778

### **Radiation Oncology Meeting**

March 19, 1997  
The Manor, West Orange  
201/325-2060

### **Radiology Meeting**

March 20, 1997  
Location to be announced  
609/275-1911

### **Anesthesia Seminar**

March 21-23, 1997  
Trump Plaza, Atlantic City  
609/441-6000

### **Facial Plastic Surgery**

March 26, 1997  
Garden State Arts Center, Holmdel  
908/335-0400

### **Nissan Fundoplication in Gastro-Esophageal Reflux**

March 27, 1997  
Woodbridge Developmental Center  
908/499-5500

### **Visiting Professor Lecture**

March 27, 1997  
St. Barnabas Medical Center, Livingston  
201/533-5000

### **Aspects of HIV/AIDS**

April 2, 1997  
Union Hospital  
908/687-1900

### **Postprandial Hyperglycemia**

April 2, 1997  
Rahway Hospital  
908/381-4200

### **Postprandial Hyperglycemia**

April 2, 1997  
Veterans Medical Center, Lyons  
908/647-0180

### **25th Anniversary**

April 4, 1997  
NJ Health Sciences Library Assoc.  
201/996-2326

### **Dermatology Meeting**

April 8, 1997  
Location to be announced  
609/275-1911

### **Vascular Society Meeting**

April 9, 1997  
UMDNJ, Newark  
201/982-4267

### **Head and Neck Oncology**

April 10, 1997  
Location to be announced  
609/275-1911

### **Nephrology Monthly Meeting**

April 15, 1997  
Overlook Hospital, Summit  
908/522-2000

### **Orthopaedic Society Meeting**

April 15-20, 1997  
Hyatt, Grand Cayman  
609/275-1911





# CLASSIFIED ADS

## 100 OPENINGS PHYSICIANS (MULTIPLE SPECIALTY LISTINGS)

### EXPERT WITNESS

Physicians in all medical specialties wanted to review medical malpractice complaints. Call 800-321-MDJD.

### PHYSICIAN SOUGHT

Kids and Career? Yes! P/T days/eves/or w/e's. Family Practice/Occupational Medical Center located in South Jersey near Echelon Mall. Board Certified Fam/Int or Occupational exp. This established medical center is hopeful to find a personable physician who enjoys working in an attractive surround w/ right hand staff and team player spirit. No inpt care. Comp salary, mal cov + benefits. Send CV: Box 2072, Medford, New Jersey 08055.

### NORTHERN NEW JERSEY

New Jersey—immediate full position for NJ licensed physician with BC in Internal Medicine, Occupational Medicine or Emergency Care, to join well established Center in Northern NJ. 1 to 2 years experience in Occupational Health preferred. Bilingual (Spanish), MRO Cert, IMA Cert, BCLS/ACLS Cert, and Stress testing desired but not required. Competitive salary/compensation, fringe benefits. Send CV to Center for Occupational Health, P.O. Box 280, Orange, NJ 07051.

## 110 OPENINGS PHYSICIANS

### PRIMARY CARE—CENTRAL NEW JERSEY

Internal Medicine Practice seeking BC/BE physician interested in Per Diem work with own malpractice. Call (908) 274-1777. Fax (908) 274-9363.

### PRIMARY CARE—CHERRY HILL

Seeking part time physician, flexible hours for busy specialty practice. Established protocols. No night call. Fax CV to Mathew J. Speesler, MD, (908) 873-5243 or mail to P.O. Box 6086, Somerset, NJ 08875.

## EMERGENCY PHYSICIANS

**Emergency Physician Associates** is seeking quality ED physicians for a variety of practice opportunities in NJ, PA, MD and NC. We offer physicians competitive compensation, flexible schedules, occurrence-based malpractice insurance, a variety of practice settings, and supportive Medical Directors. Interested candidates may call  
**1-800-848-EPA-1.**

### NEUROLOGIST— MONMOUTH COUNTY

I am a general neurologist, practicing in Monmouth County, New Jersey. I am looking for a concerned and mature neurologist to take over my practice in the group. Anyone interested, please respond with CV to Box #129, NEW JERSEY MEDICINE, 370 Morris Avenue, Trenton, NJ 08611. Monmouth County, New Jersey, is conveniently located between NYC and Philadelphia, each being approximately one hour by accessible public transportation. Our main attraction is the nearby Jersey shore. There are many lovely, public beaches that are within 15 minutes. People here enjoy suburban tranquility with accessible urban facilities, in addition to excellent schools, and a wonderful outdoor living environment.

## 300 OFFICE RENTALS AND LEASES

### EDISON

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### MILLBURN

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### MOORESTOWN, NEW JERSEY

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## 310 OFFICES TO SHARE

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### FORT LEE

OFFICE TO SHARE—Fort Lee, Bergen County. Professional office space available with chiropractor. Fully furnished. Ample Parking. (201) 886-8755.

## 340 REAL ESTATE (HOME/OFFICES)

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### RAMSEY—BERGEN COUNTY

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## 460 MEDICAL SERVICES

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## 510 MEDICAL EQUIPMENT WANTED

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*For more information, contact:*

J.J. Cohen, M.D., V.P. Medical Affairs  
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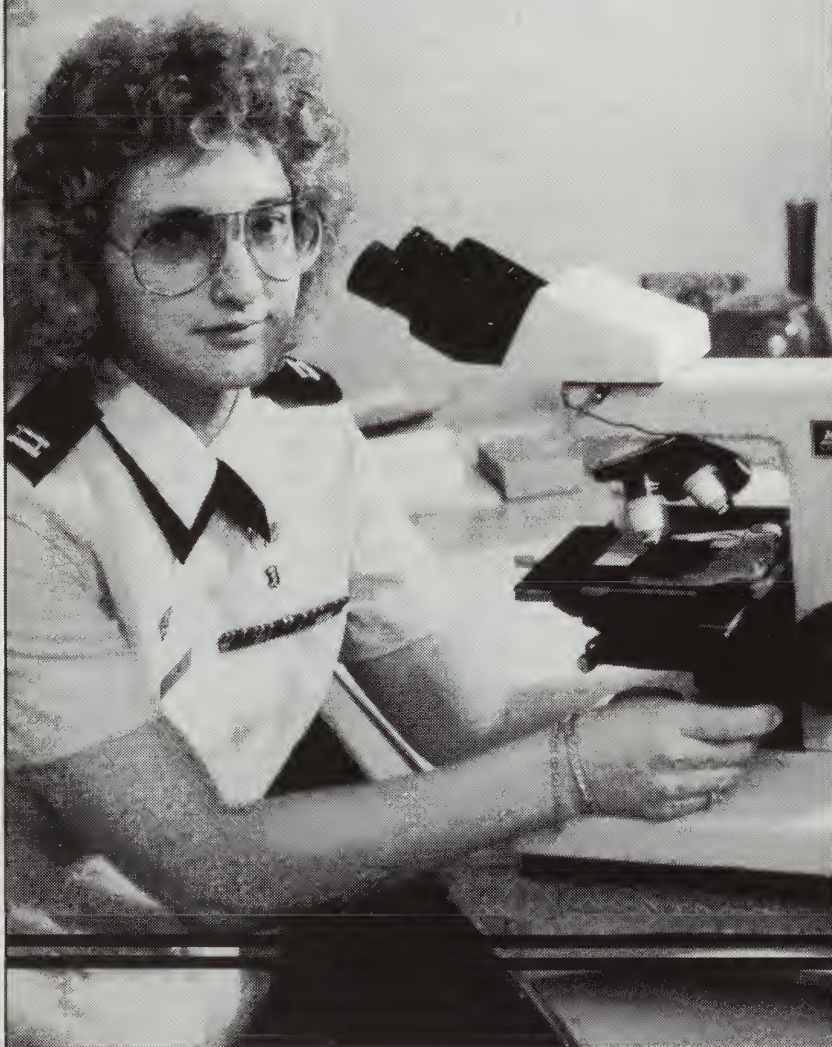
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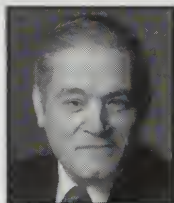
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## A first at Deborah

Javier Fernandez, MD, and his surgical team have successfully performed a minimally invasive mitral valve surgery—the first at Deborah Heart and Lung Center, in Browns Mills, which specializes in the diagnosis and treatment of adults with heart, lung, and vascular diseases and children and neonates with congenital and acquired heart defects. Dr. Fernandez is a member of the AMA, MSNJ, and the Burlington County Medical Society.



Javier Fernandez, MD

## Breast cancer research

Fact: New Jersey has the fourth highest breast cancer incidence in the United States. Fact: New Jersey ranks third in breast cancer mortality in the United States. To help eradicate breast cancer, MSNJ President Anthony Caggiano, Jr, MD, urges all New Jersey residents to contribute to the New Jersey Breast Cancer Research Fund through a check-off box on the New Jersey state income tax form. The New Jersey Breast Cancer Research Fund supports innovative research focusing on the cases, prevention, screening, treatment, and cure of breast cancer.



## Medical patents legislation

A coalition of national medical societies scored a legislative victory in a bill recently passed by Congress. The bill includes a provision banning enforcement of medical procedure patents against physicians, those acting under their direction, and related health care entities, and precludes the filing of infringement suits against medical practitioners and their related health care entities for the performance of “medical activities” that would otherwise violate patents on medical or surgical procedures.

The law was championed by two physician legislators—Representative Greg Ganske (R-Iowa) and Senator Bill Frist (R-Tennessee). The legislation helps to resolve the growing problems caused by medical procedure patents. For additional information about the law, contact Rob Portman, at Jenner & Block, 202/639-6880.

## Positions at the Department of Health and Senior Services

The Department of Health and Senior Services (DHSS) is seeking a state epidemiologist; infectious disease physicians;

and cancer epidemiologists. Contact Marianne Roth, DHSS, John Fitch Plaza, CN 360, Trenton, NJ 08625-0360.





## VISIT MSNJ ON THE WORLD WIDE WEB

The Internet is a "network of networks" that connects computers all around the world and allows millions of people to access information at any given time. It will play a major role in communications—both at the personal and business levels.

MSNJ has embraced this state-of-the-art technology to serve as an important vehicle for informing members, the entire medical community, and the public about MSNJ activities, developments in health care and health policy, and events, trends, findings, and perspectives in health care and public health. MSNJ's web site on the Internet and e-mail will be available in January 1997. The world wide web address on the Internet is <http://www.msnj.org>.

Users will be able to access medical and health care information including legislation updates, statewide meetings and events, membership information and benefits, and links to other medical web sites. In addition, users will be able to tap into MSNJ-sponsored programs like MRAC, New Jersey BREATHEs, and the Physicians' Health Program or get the late-breaking news and findings from *New Jersey MEDICINE*.

### Focus on health care legislation

Bergen County Medical Society President Joseph R. Friedlander, MD, served as the moderator for the breakfast discussion, "The State of New Jersey Health Care." A distinguished panel of legislators, including Assemblyman Nicholas R. Felice and Assemblywomen Rose M. Heck,



(Left to right) Assemblywoman Weinberg, Assemblyman Felice, Assemblywoman Vandervalk, and Dr. Friedlander.

Charlotte Vandervalk, and Loretta Weinberg, shared developments in health care legislation to an audience of physicians, hospital executives, social workers, nursing

home and home health agency directors, and the public. The session was sponsored by BCMS.

### Mandatory electronic billing

The MSNJ Board of Trustees approved the continued opposition to mandatory electronic billing for physician offices and offers the following options for physicians to follow when dealing with insurance companies that do not pay in a timely fashion:

1. Move under their contract to notice the insurance company and the New Jersey Department of Banking and Insurance of a material breach.
2. Move under their contract to collect 10 percent interest for the uncontested portion of the claim that has not been paid within 60 days after receipt of the claim by the health insurer.
3. Invoke their termination without cause.

### De Castro ascends to president-elect

Leticia De Castro, MD, has been elected president-elect of the 15,000-member Association of Philippine Physicians in America. She will assume the presidency in the summer of 1997. De Castro is active at MSNJ, serving as a delegate to the MSNJ House of Delegates and vice-chair of the Committee

of International Medical Graduates and of the Committee on Medical Student Loans. She has served on the MSNJ Board of Trustees.



Dr. DeCastro

*continued on page 71*

# .....**DRAMATIC**..... **BREAKTHROUGHS** .....**IN CHRONIC**..... **WOUND CARE** .....**ARE HERE.**.....▶



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